



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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RICHARD M. ARMSTRONG – Director

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September 3, 2015

James Hayes, Administrator
River Ridge Center
640 Filer Avenue West,
Twin Falls, ID 83301-4533

CORRECTED LETTER

Provider #: 135106

Dear Mr. Hayes:

On **August 14, 2015**, a survey was conducted at River Ridge Center by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be one that comprises a pattern that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

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

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **September 4, 2015**. Failure to submit an acceptable PoC by **September 4, 2015**, may result in the imposition of civil monetary penalties.

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

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

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

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

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

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **September 25, 2015**.

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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. Denial of payment for new admissions will be effective **November 14, 2015**. [42 CFR §488.417(a)]

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **February 14, 2016**, if substantial compliance is not achieved by that time.

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

If you believe these deficiencies have been corrected, you may contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 2; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **August 14, 2015** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

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

<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

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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 **September 4, 2015**. If your request for informal dispute resolution is received after **September 4, 2015**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, comments or concerns, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2.

Sincerely,



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

NS/
Enclosures

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

PRINTED: 11/20/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135106	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/14/2015
NAME OF PROVIDER OR SUPPLIER RIVER RIDGE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 640 FILER AVENUE WEST TWIN FALLS, ID 83301		
(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 the federal recertification and complaint survey conducted at the facility on August 10-14, 2015. The surveyors conducting the survey were: Brad Perry, BSW, LSW, Team Coordinator Linda Kelly, RN Lorraine Hutton, RN Angela Morgan, RN Survey Definitions: ADL = Activities of Daily Living BIMS = Brief Interview for Mental Status CNA = Certified Nurse Aide DON = Director of Nursing IV = Intravenous LN = Licensed Nurse LSW = Licensed Social Worker MAR = Medication Administration Record MDS = Minimum Data Set assessment ML = Milliliter PICC = Peripherally Inserted Central Catheter PRN = As Needed PTA=Physical Therapy Assistant	F 000			
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.	F 164		9/18/15	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

09/04/2015

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

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F 164	<p>Continued From page 1</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and resident and staff interview, it was determined the facility failed to maintain visual privacy during personal care for 1 of 6 sample residents (#1). This was true when Resident #1's window curtain was open and his buttock was exposed which created the potential for a negative effect on the resident' psychosocial well-being. Findings included:</p> <p>On 8/11/15 at 10:00 a.m., Resident #1 was asked if he liked to have privacy at times, to which the resident responded, "Yes."</p> <p>On 8/11/15 at 3:18 p.m., the resident's window curtain was open and his buttocks exposed to a parked vehicles in the parking lot outside as LN #2 prepared to provide wound care. When shown</p>	F 164	<p>F-164 Affected On 08/12/2015, resident #1 was assessed by the Resident Service Director and Unit Manager. No signs and/or symptoms of psychosocial harm were found" LN #2 was re-educated by the Director of Nursing Service on 08/11/2015 on providing dignity and privacy during personal cares and treatments. Potential On or before 09/18/2015, residents receiving personal care will be identified and assessed by the Resident Service Director, and Unit manager for signs and/or symptoms of psychosocial harm</p>		

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F 164	Continued From page 2 the open window curtain, the LN immediately closed the curtain. Immediately after the LN left the room, the resident was asked how he felt about his buttock being exposed when the window curtain was open. The resident stated, "Don't like it."	F 164	regarding privacy issues. Any negative findings will be addressed." Systemic On or before 09/18/2015, employees will receive education by the Nurse Practice Educator regarding resident privacy with emphasis on outside window coverings." On or before 09/18/2015, caregiving staff and facility management will receive education from the Nurse Practice Educator and Facility Administrator regarding resident privacy and regular rounding to assess compliance. On or before 09/18/2015, current daily manager rounds will include observations for privacy issues. Issues found will be corrected and reported to the Director of Nursing. QA-PI On or before 09/18/2015, weekly audits of privacy rounds will be conducted by the Director of Nursing in the Cares Meeting. She will report results and any necessary corrections at the monthly QA-PI meeting for review and remedial intervention for 3 months or until resolved. The Director of Nursing is responsible for monitoring and follow-up."		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.	F 242		9/18/15	

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F 242	<p>Continued From page 3</p> <p>This REQUIREMENT is not met as evidenced by: Based on a complaint from the public, interviews and medical record review, it was determined the facility failed to ensure all residents were permitted to make food choices. This affected 1 of 10 sampled residents (#7) who experienced emotional distress when she was not provided a meal menu from which to choose her meals until several days after admission to the facility. Findings included:</p> <p>Resident #7 was admitted to the facility on 4/4/15 with diagnoses including osteopenia.</p> <p>The resident's admission MDS assessment, dated 4/11/15, coded the resident was cognitively intact, able to make decisions, had no long- or short term memory impairment, and fed herself independently.</p> <p>The resident's 4/11/15 Admission Orders included a diet for 4 carbohydrate choices per meal and regular texture food. The resident's record contained no documentation that the Facility's Food and Nutrition Services spoke with the resident about her food preferences until 4/13/15, nine days after the resident's admission.</p> <p>On 4/13/15, the CDM interviewed the resident for food choices and then decided upon a "Choice Plan," which enables residents to choose their next day's meals from a menu. If residents do not participate on the Choice Plan, the CDM said, they are provided the main menu choice for the meal, but those who do not like the selection can</p>	F 242	<p>F-242 Affected On 04/13/2015, resident #7 was interviewed by the Certified Dietary Manager regarding food preferences and placed on the choice menu plan." Potential On or before 09/14/2015, residents will be re-assessed by the Certified Dietary Manager to insure that those who selected choice menu/ meal preferences were implemented in a timely manner. Any negative findings will be corrected on or before 08/22/2015." Systemic On 09/14/2015, the Certified Dietary Manager received education from the facility Administrator regarding the need to complete food preference interviews and inputting resident's choice menus on a timely basis." On or before 09/04/2015, food preference input and resident choice menu shall be reviewed and confirmed by the Resident Service Director at the 72-hour Admission Conference. New Admissions are reviewed at weekly CAR (Customer at Risk) meeting. On or before 09/14/2015, food preference and choice menus will be added by the Director of Nursing to the agenda. The Certified Dietary Manager trained additional dietary staff on 08/27/2015 related to implementing the choice menu</p>		

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F 242	Continued From page 4 ask for an alternate. The CDM stated she usually completes an interview within a few days of a resident's admission, but because of circumstance she was delayed in meeting with Resident #7. During an interview on 8/14/15 at 10:15 am, the facility's Certified Dietary Manager (CDM) stated she was "working the floor" the first few days after the resident's admission. The CDM stated she then left town to attend meetings and was unable to complete the Food Preference List for Resident #7 until she returned. The CDM stated the day she came back to the facility, at least 4 staff asked her to speak with the resident about her diet because she was quite distressed and kept asking for menus.	F 242	in the event the dietary manager is unable to implement the choice menu/ dietary preferences. QAPI Beginning the week of 09/14/2015 new admissions will be reviewed by the administrator or designee to ensure that dietary preferences including choice menu were implemented within a timely manner weekly X 4weeks and then monthly X 2months. The results of these audits will be reported to the QA committee for review and remedial intervention X3 months or until resolved. The administrator is responsible for monitoring and follow-up. "		
F 248 SS=E	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review, group and individual resident interview, and staff interview, it was determined the facility failed to provide an ongoing weekend activities program. This was true for 1 of 9 (#13) sampled residents and 4 of 6 residents who attended a group interview, and had the potential to adversely affect the psychosocial well-being of most residents in the facility through boredom and possible increase in	F 248	F-248 Affected On 08/21/2015, resident # 13 was assessed by the Resident Service Director for signs and/or symptoms of adverse psychosocial well-being with no negative affects found. " Weekend activities were added to the activity calendar and implemented on	9/18/15	

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F 248	<p>Continued From page 5 negative behaviors. Findings included:</p> <p>The Activity Calendars for May through August 2015 documented: *Saturdays-10:30-News/Stories and 1:30 Bingo, two of the Saturdays in June also documented an additional activity of Picnic Day and Fishing Derby, and *Sundays-10:00-LDS Service and Catholic Communion.</p> <p>During the resident Group Interview on 8/11/15 at 1:30 PM, 4 of the 6 residents in attendance said there were not enough activities on weekends. One resident said there was "not much going on. It's kinda lonesome on weekends. Activities [staff] doesn't work on weekends."</p> <p>On 8/13/15 at 11:10 AM, Resident #13 said there were "no" activites on the weekends.</p> <p>On 8/13/15 at 10:30 AM, Activity Manager #3 said the activity assistant who worked on Saturdays had quit in May and the facility had not held Saturday activities since then, except the Fishing Derby activity on 6/27/15. She said residents had complained about the lack of activities and the facility had hired a new Activity Director, but that person was still in training and had only been working Monday through Friday with Activity Manager #3. When asked why the June through August activity calendars still reflected Saturday activities, she said the facility thought they had a volunteer who would work Saturdays, but that had not happened.</p> <p>On 8/13/15 at 2:55 PM, the Administrator was interviewed about the activity calendar. He said</p>	F 248	<p>09/08/2015 by the Activity Director. Potential On or before 09/18/2015, residents will be assessed by the Resident Services Director for signs and/or symptoms of adverse psychosocial well-being, with any adverse findings treated." A resident council meeting will be held on 09/15/2015 by the Resident Care Director_ to review weekend activities preferences. The activity calendar was updated by the Activity Director as indicated. Systemic Effective 09/21/2015, The Activity Director's schedule will be revised by the Resident Services Director to include weekend hours." Beginning 09/01/2015 Residents will be interviewed in the resident council meeting monthly by the administrator or designee related to their satisfaction with the centers activity programming. Employee hours are currently reviewed daily by the Administrator. Effective 08/21/2015, the weekend Activity Director's hours will be reviewed each Monday. QAPI Beginning the week of 09/01/2015, weekend activities will be reviewed in the Monday Stand-Up meeting by the Administrator or designee to ensure that resident's recreational needs are met weekly X4 weeks and then monthly X 2monhts. The results of these audits will be reported to the QA committee for review and remedial intervention X3</p>		

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F 248	Continued From page 6 he was optimistic they would have a weekend activities volunteer and that he notified residents about the Saturday activity cancellations, but those activities should have been deleted from the Activities calendar.	F 248	months or until resolved. The Administrator is responsible for monitoring and follow up."		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to recognize worsening signs of depression and ensure safety notifications were made to qualified professionals to rule out suicidal ideation. This was true for 1 of 4 (#2) residents sampled for depressive symptoms. Findings included: Resident #2 was readmitted to the facility on 5/13/13 with multiple diagnoses including depression and obesity. The resident's 4/10/15 Social Services Assessment documented the resident had mild depression. The resident's 7/10/15 Social Services Assessment documented the resident had moderately severe depression, and noted, "...depression [up and down], has bad days, tearful, unhappy with self image..." Care plans dated 10/29/14 and 3/20/15,	F 250	F-250 Affected On 07/27/2015, resident #2 was assessed by the Licensed Social Worker for signs and symptoms of depression / suicidal ideation and the resident's plan of care was updated. " The resident was reassessed by the Psychiatrist on 08/13/2015. Psychiatrist recommendations were reviewed by the IDT on 08/27/2015, and resident's plan of care was updated by the director of nursing on 08/27/2015. Potential On or before 09/18/2015, residents with diagnosis of depression will be reviewed for signs or symptoms of depression or suicidal ideations .need of additional Social Service support by the Licensed Social Worker will be provided as indicated."	9/18/15	

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F 250	<p>Continued From page 7</p> <p>documented, "Social Worker will help identify triggers of depression as needed," and "Monitor for increased [signs and symptoms] of depression."</p> <p>The resident's July and August 2015 Medication Review Report documented an order, dated 9/24/14, for Trazodone for depressive disorder.</p> <p>The resident's Nursing notes documented the following: -7/10/15, 5:50 PM, "...This AM res[ident] was tearful [and] when asked what was wrong she stated, 'Because of my condition. Being fat [and] in bed for the rest of my life!' Asked if I could do anything for her [and] she stated, 'A gun to my head!' Comfort was provided [and] reminder that she has visitors that come [and] care about her...Was able to calm down shortly after [and] was ok until lunch time [and] she became tearful again but did not want to talk...When PM pills were given res was smiling [and] stated, 'I'm felling better.' Will continue to monitor." -7/11/15, 7:25 AM, "...[zero] tearful behaviors observed."</p> <p>The resident's Social Service notes documented the following: -7/27/15, "Resident tearful and shared [with] LSW that she feels depressed daily but it comes and goes through out the day...Resident does not have a plan for self harm and told LSW it was against her religion...LSW offered counseling services by licensed therapist and educated about the benefits of talking [with] a counselor. Res does not want this service." -8/3/15, "Res less tearful today although staff report res continues to cry almost daily...LSW</p>	F 250	<p>Systemic</p> <p>The Resident Service Director will be counseled and educated regarding the need for timely assessments in the event of psychosocial change of condition including signs and symptoms of increased depression or suicidal ideation on or before 09/18/2015 by the Licensed Social Worker. "</p> <p>On or before 09/18/2015, psychosocial changes will be reported by the Resident Service Director in the daily clinical meeting and reviewed in the weekly Cares meeting to insure timely follow-up by the Licensed Social Worker.</p> <p>The Licensed Social worker will attend the centers CAR (customer at risk) resident review meeting at least monthly beginning the week of 09/14/2015.</p> <p>QAPI</p> <p>Beginning the week of 09/14/2015 the Director of nursing or designee will review 3 residents for signs or symptoms of increased depression or suicidal ideation including Social Services follow-up as indicated. These audits will be completed weekly X4 weeks and then monthly X 2 months. The results of the audits will be reported to the QA committee for review and remedial intervention monthly X3 months or until resolved. The Director of Nursing is responsible for monitoring and follow up. "</p>		

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

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F 250	Continued From page 8 again explained about benefits of counseling...Res told LSW she doesn't think it will help but will give it a try." The resident received a Physician's order on 8/3/15 for counseling which began on 8/4/15. On 8/13/15 at 8:25 AM, Resident #2 was interviewed regarding her depression. She said she did not remember social services talking to her after the incident in July, but recalled speaking with social services near the end of July for possible counseling. She said she would never harm herself because it was against her religion. On 8/13/15 at 3:50 PM, the Resident Service Director was interviewed. She said she completed the 7/10/15 assessment with the resident and did not refer the LSW to visit with the resident until 7/27/15. She said based on the assessment she should have made a referral at that time. She also said she did not remember if the 7/10/15 nursing note was brought to her attention or not. On 8/13/15 at 4:10 PM, the DON was interviewed. She reviewed the nursing note from 7/10/15 and said that nurse no longer worked in the facility and this was the first time the note had been brought to her attention.	F 250			
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.	F 253		9/18/15	

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F 253	<p>Continued From page 9</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure: *Wooden cabinets under the sinks in resident room #'s 112, 118, 124, 131, and 201 were free of marred and scratched wood; *Walls were not damaged in resident room #'s 112, 118 and 307; and, *An entertainment center in the TV lounge was free of scratches. This had the potential to decrease the quality of life of residents who resided or frequented these areas. Findings included:</p> <p>1. On 8/10/15 from 1:15 to 1:25 PM and 8/11/15 from 11:05 to 11:16 AM, the wood cabinets beneath the sinks in rooms 112, 118, 124, 131, and 201 were observed to be marred and scratched at multiple places on the drawers and to the side of the cabinets.</p> <p>2. On 8/10/15 at 1:25 PM and 8/11/15 from 11:05 to 11:10 AM, the wall near the bed in Room 307 contained 5 areas where the paint had peeled off and the walls under the sinks in rooms 112 and 118 had missing plaster with multiple gouges in the wall and an exposed metal corner flashing.</p> <p>3. On 8/10/15 at 3:30 PM, the bottom side of the entertainment center in the TV lounge was observed with a two-inch by six-inch scratch in the wood.</p> <p>On 8/13/15 from 8:30 to 8:55 AM, during the environmental tour, the Maintenance Supervisor said the identified areas would be repaired.</p>	F 253	<p>F-253 Affected On or before 09/18/2015, the wooden cabinets under the sinks in room's #s 112, 118, 124, 131, and 201 will be refinished/repared by the Maintenance Director as needed." On or before 09/18/2015, the walls in room #s 112, 118, and 307 will be repaired/refinished by the Maintenance Director as needed. On or before 09/18/2015, the scratches in the entertainment center will be refinished by the Maintenance Director. Potential On or before 09/18/2015, the Maintenance Director will inspect resident rooms and public areas and repair any areas identified." Systemic On or before 09/18/2015, the monthly Housekeeping audit will be amended by the Administrator to include maintenance items & observations, and the Maintenance Director will accompany the Housekeeping Supervisor and Administrator on the audit round." QAPI Beginning the week of 09/07/2015 an environmental round will be completed by the Administrator or designee to ensure that maintenance issues are identified and corrected weekly X4 weeks and then monthly X2 months. The results of these audits will be reported to the QA</p>		

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F 253	Continued From page 10	F 253			
F 280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>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.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to revise care plans for 2 of 13 (#s 3 and 4) sampled residents. The care plans: *Did not include a fall intervention which was in place; *Contained an intervention to float heels, which</p>	F 280	<p>committee for review and remedial intervention X2 months or until resolved. The administrator is responsible for monitoring and follow up.</p> <p>F-280 Affected On 08/14/2015, the care plan for resident #3 was reviewed and updated by the Unit Manager. The reference to floating heels was removed." On 08/13/2015, the care plan for resident</p>	9/18/15	

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F 280	<p>Continued From page 11 was no longer in use. This had the potential to result in harm if residents did not receive appropriate care due to lack of direction in their care plans. Findings included:</p> <p>1. Resident #4 was admitted to the facility on 9/1/13 with multiple diagnoses, including dementia and unspecified arthropathy (joint disease).</p> <p>The resident's overflow Fall Care Plan documented an intervention on 5/26/15 for the bed to be placed in the low position, due to lack of safety awareness. The resident's current Fall Care Plan did not document the intervention.</p> <p>On 8/11/15 at 9:12 AM, the resident was observed as he was transferred by two staff members from a wheelchair to his bed, which was in the low position.</p> <p>On 8/13/15 at 10:25 AM, the DON provided a copy of the low position intervention from the overflow chart and said it should have been added to the current Care Plan.</p> <p>2. Resident #3 was admitted to the facility on 6/30/15 with multiple diagnoses, including muscular wasting.</p> <p>Resident #3's Skin Integrity Care Plan, dated 7/7/15, documented staff were to float the resident's heels while he was in bed.</p> <p>Resident #3 was observed lying in his bed without a heel float device in place on:</p>	F 280	<p>#4 was reviewed and updated by the Unit Manager to include the bed placement in low position due to the resident's poor safety awareness.</p> <p>Residents #3 and #4 were assessed by the director of nursing or designee on 08/13/2015 and 08/14/2015 respectively, with no adverse effects related to unclear plan of care noted.</p> <p>Potential</p> <p>On or before 09/18/2015, resident care plans will be reviewed by The Unit Manager, MDS-Case Manager, and Director of Nursing for accuracy, with corrections entered as necessary."</p> <p>"Systemic</p> <p>On or before 09/18/2015, care plans updates will no longer be handwritten, but entered by the licensed nurses into the electronic record. Care plan revision summaries shall be reviewed weekly by the Director of Nursing or designee to insure accuracy."</p> <p>On or before 09/18/2015 center staff who update care plans will be re-educated by the Director of Nursing related to updating care plans to reflect resident condition and care and services provided.</p> <p>QAPI</p> <p>Beginning the week of 09/14/2015, a review of 3 resident care plans will be completed by the director of nursing or designee to ensure that care plans accurately reflect resident condition and care and services provided weekly X4 weeks and then monthly X2 months. The results of these audits will be reported to the QA committee for review and remedial</p>		

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F 280	Continued From page 12 *8/10/15: 3:30 PM; 3:50 PM *8/11/15: 9:55 AM; 10:10 AM; 11:30 AM; 2:50 PM *8/12/15: 10:20 AM; 2:42 PM *8/13/15: 9:27 AM On 8/12/15 at 4:00 PM, CNA #8 was asked if Resident #3's heels should be floated while she was providing cares to the resident in bed. CNA #8 said the resident's heels should be floated and then placed a pillow underneath the resident's lower extremities to float his heels On 8/13/15 at 9:27 AM, PTA #7, when asked if Resident #3's heels should be floated while he was providing cares to the resident in bed, said, "I don't think so." On 8/14/15 at 11:10 PM, UM #1, when asked whether the resident's heels should be floated while in bed, stated it was no longer necessary to float Resident #3's heels. UM #1 stated the resident's care plan should have been updated.	F 280	intervention X2 months or until resolved. The Director of nursing is responsible for monitoring and oversight.		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility failed to clarify medication orders for one random resident (#14). The failures created the potential for Random Resident #14 to receive the wrong dose of aspirin and diurectic medication. Findings included:	F 281	F-281 Affected On 08/14/2015, the medication orders for resident #14 were reconciled by the Director of Nursing with the Urologist's discharge summary with no medication changes to resident's current regimen	9/18/15	

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F 281	Continued From page 13 Resident #14 was admitted to the facility on 4/22/15 with a diagnosis of Urinary Tract Infection (UTI). The resident returned to the facility following an outpatient surgical procedure on 8/5/15. A Physician's Order titled, "Discharge Medication," dated 8/5/15, directed staff to provide: *Aspirin (ASA) 325 mg daily *Furosemide (Lasix) 20 mg twice daily The recapitulated August 2015 Physician's Orders, dated 8/5/15, documented: *Aspirin 81 mg tablet *Furosemide tablet 40 mg On 8/10/15 at 9:34 AM, LN #2 was observed administering one Furosemide 40 mg tablet and Aspirin 81 mg to Resident #14. The DON, when asked about the disparity in the discharge orders and the current recapitulated orders, stated the discharge orders were in error, had failed to be noted by facility staff, and should have been clarified to reflect the recapitulated August 2015 Physician's Orders.	F 281	required. " Potential On 08/31/2015, resident medication orders were reviewed by the Director of Nursing and Unit manager during the monthly medication recapitulation. Changes were updated and clarified as needed." "Systemic Effective 09/08/2015, orders for residents returning from hospital or day surgeries will be reconciled for accuracy during the daily clinical meeting by the (Director of Nursing, Unit Manager, IDT), who will also follow-up with the respective physician or caregiver as needed." On or before 09/18/2015, licensed nurses will be reeducated by the Director of Nursing on clarifying unclear orders at time of receipt by the Director of Nursing. QAPI Beginning the week of 09/18/2015, a review of 3 residents medication orders will be completed by the Director of nursing or designee to ensure that clarifications are made as indicated weekly X4 weeks and then monthly X2 months. The results of these audits will be reported to the QA committee for review and remedial intervention monthly X3 months or until resolved. The Director of nursing is responsible for review and follow up.		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain	F 309		9/18/15	

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F 309	<p>Continued From page 14</p> <p>or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and record review, it was determined the facility failed to ensure residents' identified medical needs received care and treatment as needed and care plans were followed. This was true for 2 of 14 residents (#s 1 & 9) sampled for quality of care: * Resident #9 was put at risk for infection and his PICC line not being patent (ready for use) when the facility failed to obtain orders for the care and maintenance of the PICC line. * Resident #1 was put at risk for wound deterioration/not healing of the left heel when staff failed to off-load his heels when he was in bed.</p> <p>Findings Included:</p> <p>1. Resident #9 was readmitted to the facility on 7/11/14 with diagnoses including Cauda Equina Syndrome and post incision and drainage of lumbar spine wound infection.</p> <p>Hospital discharge records documented a PICC line was placed on 7/10/14. The PICC Line Post Insertion Orders directed staff to change the PICC line dressing per policy, and flush unused ports with 10 ml normal saline every 12 hours for inpatients and every 24 hours for outpatients. Staff were directed not to draw coagulation labs</p>	F 309	<p>F-309 Affected On 08/13/2015, Resident #1 was assessed by the Unit Manager for negative wound outcome. The wound is now resolved." Resident #1 was provided with a heel off-loading device by the Licensed Nurse on 08/12/2015, and the care plan was revised on 08/28/2015 to reflect resident mobility and need to reposition heels. Resident #1 skin was assessed by the Unit Manager on 08/13/2015 with no new skin issues and no deterioration of current skin conditions noted. Resident # 9 was discharged on 07/15/2014 Potential On 08/22/2015, the physician discharge orders for residents admitted in the last thirty days were reconciled with the admission assessments and care plans to ensure that orders were implemented including any PICC line orders. No errors were found." On or before 09/18/2015, a center round will be completed by the Director of Nursing to ensure that care planned interventions were implemented. Any</p>		

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F 309	<p>Continued From page 15 from the PICC line for 24 hours after insertion.</p> <p>Physician Progress Notes, dated 7/10 and 7/11/14 and written by the resident's surgeon, documented the resident was discharged for rehabilitation, dressing change to a back wound every other day or prn, showering permitted after 7 days with a Tegaderm dressing, follow up at clinic in 2 weeks, and required IV antibiotics, based on pending cultures. No discharge instructions were given for PICC line care and maintenance.</p> <p>The 7/11/14 admission Nursing Assessment documented Resident #9 was readmitted with a PICC line. Readmission Physician's Orders did not address care and maintenance of the PICC line, and no clarification orders were found in the resident's medical record that directed the care and maintenance of the resident's PICC line between 7/11/14 and 7/15/14.</p> <p>Physicians orders and Medication Treatment Records documented Resident #9 received therapeutic IV infusions of 250 cc of normal saline through the PICC line on 7/15 and 7/16/14. No orders for PICC line care and maintenance were provided on 7/15 or 7/16.</p> <p>Medication and Treatment Records and Nurse Progress Notes, dated 7/11/14 - 7/17/14, did not address PICC line dressing changes, flushes, or checks for patency, or a description of signs/symptoms of infection.</p> <p>During an interview on 8/14/15 at 10:30 am the DON and Regional Clinical Consultant stated the facility nurses did not obtain orders for PICC line</p>	F 309	<p>identified issues were corrected at that time.</p> <p>Systemic On or before 09/18/2015, licensed nurses will be educated by the Nurse Practice Educator regarding the need to reconcile the admission assessment with discharge orders including any PICC line orders to ensure that orders are implemented, and any needed follow up addressed in a timely manner."</p> <p>On or before 09/18/2015, new admission documentation will be reviewed in the daily clinical meeting to insure orders are in place for treatments as indicated. Beginning the week of 09/14/2015, bedside rounds will be completed by the Director of Nursing or designee for new admissions to ensure that care planned interventions/ and physician orders including PICC line orders are implemented per the plan of care.</p> <p>QAPI Beginning the week of 09/14/2015 an audit of 3 residents physicians orders (including PICC line orders) / care plans/ and bedside interventions will be completed by the Director of nursing or designee to ensure that orders and care planned interventions are implemented Weekly X4 weeks and then monthly X2</p>		

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F 309	Continued From page 16 care and maintenance between 7/11/14 and 7/17/14. 2. Resident #1 was readmitted to the facility on 7/7/15 with a suspected deep tissue injury (SDTI) to the left heel. The resident's care plan identified the risk for skin breakdown and the left heel SDTI as a focus area on 7/7/15. One of the interventions initiated on 7/7/15 included, "Float heels while in bed." In addition, the resident's 8/1/15-8/31/15 orders included the order to float the heels while in bed. On 8/12/15 at 11:20 a.m., the resident was observed in bed. LN #5, who was in the room, pulled back the bed linens for the surveyor to observe the resident's feet. A small black scab was observed on the resident's left heel. The right heel was intact and blanched, however, the resident's heels were not floated as care planned and ordered. The left heel was in contact with a pillow under the foot and the lateral aspect of the right foot/heel was in contact with the mattress. When asked if the resident's heels were supposed to be floated, the LN stated, "Yes." When asked if the resident's heels were floated, the LN stated, "No." The LN immediately repositioned the pillow and the resident's heels until they were floated.	F 309			
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater.	F 332		9/18/15	

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F 332	Continued From page 17 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility failed to ensure it was free of a medication error rate of five percent or greater. This was true for 4 of 27 observed medication passes (14.8%) and affected two Random Residents (#14 and #15) and one sampled resident (#13). This failure created the potential for residents to receive less than optimum benefit from prescribed medications or experience hypoglycemia (low blood sugar) from contraindicated doses of insulin. Findings include: 1. Random Resident #15 was admitted to the facility on 7/17/15 with multiple diagnoses, including Type I Diabetes Mellitus. The August 2015 Physician's Recapitulation Orders documented the resident was to receive 10 units of Novolog 70/30 each evening. On 8/12/15 at 11:30 PM, LN #1 was observed while she prepared 16 units of Novolog Aspart and 10 units of Novolog 70/30 for administration to Random Resident #15. LN #1 filled the insulin syringe with 16 units of Novolog Aspart and then in the same syringe she added 10 units of Novolog 70/30. The LN walked towards the resident's room when she was stopped by the surveyor and asked to review a nursing drug handbook, which documented Novolog 70/30 insulin should not be mixed with other insulins. LN #1 stated, "We have always mixed it (Novolog 70/30) with other insulins." Please refer to F333 regarding significant medication error. 2. Resident #13 was admitted to the facility on	F 332	F-332 Affected LN #1 was re-educated by the Director of Nursing on 08/12/2015, regarding insulin administration, including mixing non-compatible insulins such as Novolog, Aspart and Novolog 70/30, and drawing up and administering the correct amount. " Resident #15 received the correct medication as ordered by the physician. On 08/13/2015, LN #6 was re-educated by the Director of Nursing regarding insulin administration, including administering the dose as ordered by the attending physician. On 08/12/2015, Resident #13 received the correct insulin dosage as ordered by the physician. On 08/11/2015 LN #2 was re-educated by the Director of Nursing on timely administration of administration. Resident #14 was assessed by the licensed nurse on 08/12/2015 for adverse effects, finding none present. Potential On or before 09/18/2015, the Director of Nursing or Unit manager will conduct a med pass observation for each nurse to insure the five rights of administration are followed, with education and follow-up provided for any identified concerns." Systemic On or before 09/18/2015 licensed nurses will receive education by the Director of		

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F 332	Continued From page 18 7/6/15 with multiple diagnoses, including Type I Diabetes Mellitus. On 8/11/15 at 6:39 PM, LN #6 was observed as she prepared 11 units of Novolog 70/30 insulin into a syringe for Resident #13, whose physician's order called for 10 units of Novolog 70/30 daily before dinner. At 6:44 PM, as LN #6 was about to enter the resident's room to administer the Novolog 70/30, she was asked to verify the dosage. LN #6 checked the syringe, stated the dosage was incorrect, and injected one unit of insulin onto the floor. Please refer to F333 regarding significant medication error. 3. Resident #14 was admitted to the facility on 4/22/15 with multiple diagnoses, including neurogenic bladder. On 8/11/15 at 9:34 AM, LN #2 was observed administering two 50 mg tablets of Primidone to Resident #14. When asked why she was administering the medication after the breakfast instead of before as ordered, LN #2 said the resident preferred to receive the medication after her meal because it upset her stomach. Resident #14's August 2015 Physician Recapitulation Order documented the medication was to be given one hour before meals.	F 332	Nursing or designee on the five rights of medication administration." Medication administration competencies will be completed by the Director of Nursing or designee on or before 09/18/2015. QAPI Beginning the week of 09/14/2015, the Director of nursing or designee will complete 2 license nurse medication observation/competency audits to insure safe medication administration weekly X4 weeks and then monthly X2 months. The results of these audits will be reported to the QA committee for review and remedial intervention X3 months or until resolved. The Director of Nursing is responsible for monitoring and follow up.		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced	F 333		9/15/15	

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F 333	<p>Continued From page 19</p> <p>by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure residents did not receive contraindicated combinations- or excessive doses of insulin that could adversely affect their blood glucose levels. This was true for 2 of 4 residents (Resident #13 and Random Resident #15) whose insulin dosages observed during medication pass were incorrectly prepared. Findings included:</p> <p>1. Random Resident #15 was admitted to the facility on 7/17/15 with multiple diagnoses, including Type I Diabetes Mellitus. The August 2015 recapitulated Physician's Orders documented the resident was to receive 10 units of Novolog 70/30 each evening. On 8/12/15 at 11:30 PM, LN #1 was observed while she prepared 16 units of Novolog Aspart and 10 units of Novolog 70/30 for administration to Random Resident #15. LN #1 filled the insulin syringe with 16 units of Novolog Aspart and then in the same syringe she added 10 units of Novolog 70/30. The LN walked towards the resident's room when she was stopped by the surveyor and asked to review a nursing drug handbook, which documented Novolog 70/30 insulin should not be mixed with other insulins. On 8/12/15 at 12:05 PM, when asked about the observed insulin preparation, LN #1 stated, "We have always mixed it (Novolog 70/30) with other insulins." When she then attempted to redraw insulin from the Novolog 70/30 vial, LN #1 was asked how she could be certain the Novolog Aspart did not mix with the insulin in Novolog 70/30 vial. The LN said she could not be certain and then discarded the Novolog 70/30 vial. The LN then drew up 10 units of Novolog 70/30 in</p>	F 333	<p>F-333 Affected On 08/12/2015, LN #1 was re-educated regarding insulin administration, including mixing non-compatible insulins such as Novolog Aspart and Novolog 70/30, and drawing up and administering the correct amount. " Resident #15 received the correct medication as ordered by the physician. On 08/13/2015, LN #6 was re-educated by the Director of Nursing regarding insulin administration, including administering the dose as ordered by the attending physician. Resident #13 received the correct insulin dosage as ordered by the physician. Potential On or before 09/18/2015, the Director of Nursing or Unit manager will conduct a med pass observation for each nurse to insure the five rights of administration are followed, with education and follow-up provided for any identified concerns." Systemic On or before 09/18/2015 licensed nurses will receive education by the Director of Nursing or designee on the five rights of medication administration." Medication administration competencies will be completed by the Director of Nursing or designee on or before 09/18/2015. QAPI Beginning the week of 09/14/2015, the Director of nursing or designee will complete 2 license nurse medication</p>		

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F 333	Continued From page 20 one syringe and Novolog Aspart in a separate syringe and administered both to Resident #15. 2. Resident #13 was admitted to the facility on 7/6/15 with multiple diagnoses, including Type I Diabetes Mellitus. Resident #13's August 2015 recapitulated Physician Orders documented the resident was to receive 10 units of Novolog 70/30 daily before dinner. On 8/11/15 at 6:39 PM, LN #6 was observed as she prepared 11 units of Novolog 70/30 insulin into a syringe for Resident #13, whose physician's order called for 10 units of Novolog 70/30 daily before dinner. At 6:44 PM, as LN #6 was about to enter the resident's room to administer the Novolog 70/30, she was asked to verify the dosage. LN #6 checked the syringe, stated the dosage was incorrect, and injected one unit of insulin onto the floor. "Medical-Surgical Nursing - Assessment and Management of Clinical Problems," 6th ed., by Lewis, Heitkemper, and Dirksen, documented, "A problem that may arise from too much insulin ... is hypoglycemia ... hypoglycemia worsens rapidly and constitutes a serious threat if action is not immediately taken. (p.1290).	F 333	observation/competency audits to insure safe medication administration weekly X4 weeks and then monthly X2 months. The results of these audits will be reported to the QA committee for review and remedial intervention X3 months or until resolved. The Director of Nursing is responsible for monitoring and follow up.		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 431		9/18/15	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 431	<p>Continued From page 21</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure medications were labeled in accordance with current physician orders and that expired medications were not available for administration to residents. This was true for one random resident (#15) and any resident who required Aplisol to screen for tuberculosis (TB). This failure created the potential for Resident #15 to receive the wrong dose of insulin and unreliable results for those residents who required TB</p>	F 431	<p>F-431 Affected On 08/12/2015 the pharmacy was contacted by the Unit Manager. The order was reviewed and a change of direction label was placed on the vial." On 08/12/2015 the undated and outdated Aplisol TB solution was destroyed by the Director of Nursing. Potential A medication and storage audit (including</p>		

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F 431	<p>Continued From page 22 screening. Findings include:</p> <p>1. Resident #15 was admitted to the facility on 7/17/2015 with a secondary diagnosis of Diabetes Mellitus.</p> <p>On 8/12/15 at 12:10 PM, LN # 1 was observed as she drew up Novolog 70/30 insulin 10 units for Resident #15. The pharmacy label documented the Novolog 70/30 was to be administered in the morning and in the evening. The pharmacy label did not include a dose at lunch. Prior to administration of the insulin, the LN was asked about the pharmacy label which did not include a dose at lunch. The LN said the Novolog 70/30 order was changed to include a dose at lunch. The resident's 7/29/15 Physician 's Order documented, "Novolog mix 70/30. . . inject 10 units at lunch." In addition, the resident's August 2015 MAR documented 10 units of Novolog 70/30 at lunch was added on 7/30/15.</p> <p>2. On 8/12/15 at 11:25 AM, the medication refrigerator for the 100/200/300 halls was inspected with LN #1 present. Two open vials of Aplisol (tuberculin purified protein derivative (PPD)) were observed with the seal broken. The open date on one of the PPD vials was dated 6/20/15. The second vial of PPD did not have an open date.</p> <p>The LN provided the package information insert for the Aplisol. The Aplisol manufacturer recommendations included, "Storage...Vials in use more than 30 days should be discarded due to possible oxidation and degradation which may affect potency."</p> <p>LN #1 confirmed one Aplisol vial was available for use for more than 30 days after it was opened and she did not know when the undated vial had been opened. The LN said she would dispose of both of the opened Aplisol vials.</p>	F 431	<p>medication rooms and medication carts) was completed by the Pharmacist on or before 09/18/15 to insure medications were labeled per MD order and dated as indicated."</p> <p>Systemic On or before 09/18/2015 licensed staff will be educated by the Director of Nursing or designee regarding on drug labeling and storage."</p> <p>Licensed nurses will complete a post- test to validate competencies with respect to drug labeling and storage on or before 09/18/2015.</p> <p>QAPI On or before 09/18/2015, an audit of med room/med cart will be completed by the Director of Nursing or designee to ensure compliance with medication labeling and storage, weekly for 4 weeks and monthly for 2 months."</p> <p>The audits will be reported by the Director of Nursing in the monthly QA-PI meeting for review and remedial intervention. Monthly X 3 months or until resolved. The director of nursing is responsible for monitoring and follow up.</p>		

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F 441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p>	F 441		9/18/15	

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F 441	<p>Continued From page 24</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure infection control measures were consistently implemented for two sampled residents (#3 and #13) and one random resident (#14). Failure to perform hand hygiene after personal cares for Resident #3, direct contact with Resident #14's indwelling urinary catheter, and an injection administered to Resident #13 without staff wearing gloves created the potential for cross-contamination of infection-causing organisms. Findings included:</p> <p>1. On 8/11/15 at 09:35 AM, LN #2 was observed when flushing Resident #14's indwelling urinary catheter. The LN removed her gloves then handled Resident #14's bed linens, television remote control and handed her a tissue. The LN, when asked about washing her hands, stated she did not perform hand hygiene after removing her gloves.</p> <p>2. On 8/11/15 at 6:30 PM, LN #6 was observed during a medication pass. * LN #6 administered Novolog 10 units to Resident #13. LN #6 washed her hands, but did not don gloves before administering a Novolog injection to Resident #13. Following the insulin injection, LN #6 did not perform hand hygiene. When questioned following the observation, LN #6 acknowledged she did not wear gloves or perform hand hygiene.</p> <p>3. On 8/13/15 at 09:27 AM, PTA #7 was observed propelling Resident #3 to his room, where he assisted the resident into bed, removed his glasses, wrote on his communication board,</p>	F 441	<p>F-441 Affected On 08/13/2015 Residents #3, #13, and #14 were assessed by the Unit Manager for signs and symptoms of infection. No adverse symptoms were noted." On or before 09/18/2015 staff members LN #6, LN #2, PTA #7 will be educated by the Director of Nursing or designee as to the importance of proper hand washing and infection control. Systemic On or before 09/18/2015, handwashing competency reviews will be completed all staff members by the Unit Manager or Designee." On 08/13/2015, pocket hand sanitizers were provided to all staff members and the center supply room was stocked with additional hand sanitizer. . QAPI On or before 09/18/2015 a weekly audit of five resident cares will be completed by the DON or designee to insure adequate handwashing, weekly for 4 weeks, then monthly for 2 months. The results of these audits will be reported to the performance improvement committee for review and remedial</p>		

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F 441	Continued From page 25 then walked out of the room. PTA #7 touched the railing on the wall in the hallway, went to the nursing station, and removed the ADL binder. When he was asked when he would perform hand hygiene he stated, "I wouldn't [wash my hands]. No, I will do it now." PTA #7 then washed his hands with soap and water.	F 441			



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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September 14, 2015

James H. Hayes, Administrator
River Ridge Center
640 Filer Avenue West
Twin Falls, ID 83301-4533

Provider #: 135106

Dear Mr. Hayes:

On **August 14, 2015**, an unannounced on-site complaint survey was conducted at River Ridge Center. This complaint was investigated in conjunction with the facility's recertification survey.

During the complaint investigation:

- Residents' hospital records, medical records and closed records were reviewed as well as facility's policies and procedures, accident and incident reports, grievance logs and Resident Council minutes.
- Observations for similar concerns; such as nursing care, housekeeping issues and physical therapy sessions occurred throughout the survey.
- Interviews were conducted with nursing, therapy, housekeeping, social service and administrative staff specific to the issues of the complaint.

The complaint allegations, findings and conclusions are as follows:

Complaint #6885

ALLEGATION #1:

The facility failed to provide needed adaptive equipment (a cup with handles on both sides,) which the resident needed to drink fluids.

FINDINGS #1:

The identified resident's hospital discharge orders did not include the use of any adaptive equipment for eating. The Interagency Discharge Information sheet from the hospital listed no adaptive equipment for eating or drinking.

The facility's admission orders did not include orders for adaptive equipment for eating or drinking. The admission nursing listed no special equipment for eating or drinking.

Following an occupational therapy assessment the day after admission, an order was sent to the kitchen to send a double handled cup with a spout on the resident meal trays.

The facility was not notified prior to the resident's admission or with his admission orders that he required an adaptive cup for drinking fluids. However, the cup was ordered for the resident's afternoon and evening meals the day following his admission. No deficient practice was found.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

Resident fell in bedroom and cut his hand on bedside table. Staff treated this with a butterfly bandage.

FINDINGS #2:

Nursing notes and accident and incident reports documented the resident fell in his room six days after admission. As a result of the fall, the resident acquired multiple skin tears including one to the back of his left hand. Nursing staff documented the resident's physician was notified of the falls and skin tears. Orders were received for the treatment and dressing of the skin tears. Follow-up nursing notes for the next three days documented no increased drainage or signs or symptoms of infection. The resident discharged from the facility on February 6, 2015.

The facility identified and assessed the skin tears, called the physician for orders and monitored the condition of the skin tears as required by federal regulations. No deficient practice was found.

CONCLUSIONS:

Substantiated. No deficiencies related to the allegation are cited.

ALLEGATION #3:

The resident's family normally did the resident's laundry. The facility staff took the resident's clothing to the facility's laundry and washed trousers with belt and belt buckle attached. The belt and belt buckle were ruined. The facility offered to replace it but at a lower cost than the family paid for it.

FINDINGS #3:

The federal regulations require each resident have the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to lost clothing. The intent of the regulation is to assure that after receiving a complaint/grievance the facility actively seeks a resolution and keeps the resident appropriately apprised of its progress toward resolution.

A Grievance/Concern Form documented the facility acknowledged washing the resident's clothing without removing a leather belt and buckle. The Grievance/Concern Form stated the belt was ruined and the facility would replace the belt. The grievance was eventually resolved when the belt/buckle was replaced at full cost.

The facility's actions met the intent of the regulation and no deficient practice was found.

CONCLUSIONS:

Substantiated. No deficiencies related to the allegation are cited.

ALLEGATION #4:

On at least two occasions, nursing staff only partially cleaned food, fluid and urine spills from the residents' environment before leaving the room and saying housekeeping would be in to finish cleaning. Floor and over bed table were left sticky for three to five days.

After family complained, housekeeping cleaned the floor with "soap and water."

FINDINGS #4:

A Grievance/Concern Form documented a family member notified the facility that the identified resident's floor and underside of the bedside table were sticky. Corrective actions listed on the form and signed by the Housekeeping Manager documented the cleaning product used at the time

had a high Ph level and would leave a sticky residue after repeated applications. The plan was to clean the floor with soap and water until a new cleaning chemical was obtained.

The Corrective Action Plan for the sticky bedside table was to clean the resident's bedside table thoroughly and to check and clean all the other residents' bedside table.

During interviews facility's two nurses stated when food, fluid or urine spills occur, the spills are wiped up to ensure there are no safety hazards and housekeeping is notified that the floor needs to be mopped and/or affected surfaces cleaned. The Housekeeping Manger stated the nurses do not have the equipment or chemicals to do a thorough cleaning job. Nursing staffs' responsibility is to make sure the environment is safe from spill hazards and then notify housekeeping to do a thorough cleaning. Housekeeping staff go to the room or spill area as soon as possible to mop the floor and clean the area.

The facility corrected the housekeeping issues when notified and no further complaints had been received. No deficient practice was cited.

CONCLUSIONS:

Substantiated. No deficiencies related to the allegation are cited.

ALLEGATION #5:

Resident was kept in wheelchair and not provided opportunities to ambulate.

FINDINGS #5:

Based on medical records the resident received occupational and physical therapy services five days week. Both of these services worked on transferring and ambulation skills due to the resident's unsteady gait and lack of safety awareness.

Nurses notes documented the resident was either assisted to ambulate or independently ambulated to the bathroom and into the hall.

During interviews with the physical therapist and the physical therapy aide, the resident was receiving active physical therapy to improve ambulation.

It could not be determined that the resident was kept in his chair and not given opportunities to ambulate.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #6:

Resident did not receive physical therapy services. Physical therapy staff stated they "didn't have time to do that with every patient."

FINDINGS #6:

Physician's orders for the identified resident listed skilled physical therapy services five times a week for thirty days for therapeutic exercises, gait training and neuromuscular re-education.

A physical therapy evaluation was completed the day after admission and physical therapy sessions were documented on seven of the resident's ten-day stay, including the day of discharge. The resident also received occupational therapy during this same time.

Interviews were conducted with the physical therapist and the physical therapy. Both stated they recalled working with the identified resident. Neither recalled any concerns expressed to them regarding the resident not receiving physical therapy service.

The facility documented following physician's orders in providing the resident physical therapy services. No deficient practice was cited.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #7:

Family was told the resident was on hospice while in the facility. The resident was not on hospice until he went home.

FINDINGS #7:

Physician's orders during the resident's stay did not include an order for hospice services while the resident was living at the facility.

An Interdisciplinary Team Care Review note documented the resident's stay would be short term with a probable return to home on hospice care. The note stated the family and physician were still deciding about hospice care.

A Home Health and Hospice Face to Face Encounter note signed by the resident's physician documented the resident was eligible for and would benefit by home hospice care. A discharge order was written for the resident to return home with hospice services.

Nurses notes documented no hospice services were rendered during the resident's stay in the facility.

The facility planned for and assisted the resident to receive hospice services upon discharge. No deficient practice was cited.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #8:

Family did not receive the resident's medications when he was discharged from the facility.

FINDINGS #8:

The facility's pharmacy services manual documented a physician/prescriber must order discharge medications be sent home with the resident from the facility. The resident's physician signed discharge orders stated prescriptions would be sent to the resident's pharmacy of choice for a ten to fourteen day supply of medications. No order was given for the family to take medications from the facility.

The resident was discharged home with hospice care, which would be providing any medications the resident would continue at home. The resident's family signed the Discharge Transition Plan, which included a check marked statement that, "I and/understand what my medications are, how to obtain them..."

The facility followed pharmacy guidelines and the discharge plan. No deficient practice was cited.

CONCLUSIONS:

Substantiated. No deficiencies related to the allegation are cited.

ALLEGATION #9:

Resident did not receive "Alzheimer's" medication at any time while in the facility.

FINDINGS #9:

The resident's admission orders, dated January 27, 2015, documented the resident was to receive Donepezil (Aricept) 10 milligrams by mouth every morning for memory.

James H. Hayes, Administrator
September 14, 2015
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Medication Administration Records documented the resident received the Donepezil daily throughout his stay. No deficient practice was cited.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #10:

Admission papers were not received until after the resident was discharged from the facility.

FINDINGS #10:

The facility provided a copy of an admissions agreement for the identified resident, including all of the federally required components. The agreement was signed on the date of admission to the facility.

There is no federal requirement for copies of these documents to be provided unless requested.

CONCLUSIONS:

Substantiated. No deficiencies related to the allegation are cited.

Five of the allegations were substantiated, but not cited. Therefore, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,



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

NS/dmj



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
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September 9, 2015

James H. Hayes, Administrator
River Ridge Center
640 Filer Avenue West
Twin Falls, ID 83301-4533

Provider #: 135106

Dear Mr. Hayes:

On **August 14, 2015**, an unannounced on-site complaint survey was conducted at River Ridge Center. This complaint was investigated in conjunction with the facility's recertification survey.

During the complaint investigation:

The identified resident's closed medical records were reviewed as well as facility's policies and procedures, grievance logs and Resident Council Minutes. In addition, four additional sampled residents were reviewed for wound care and treatment.

Observations for similar concerns, wound care and incontinent care occurred throughout the survey.

Interviews were conducted with nursing staff, social services and administrative staff specific to the issues of the complaint.

The complaint allegations, findings and conclusions are as follows:

Complaint #6964

ALLEGATION #1:

Facility did not provide sufficient care to a resident with multiple sores on her buttocks or receive dressing changes as ordered. Facility blamed the lack of treatment and care on resident's non-compliance.

FINDINGS #1:

Facility's assessments documented the resident was alert, oriented to person and place and had occasional confusion. The assessments documented the resident could express her wants and needs and use a call light.

During the resident's course of stay, the clinical record documented the resident was not consistently receptive to cares.

Interdisciplinary Team Meetings and Care Conferences were held frequently to discuss the risk of skin breakdown if the resident continued to refuse incontinence care. The resident and/or Health Proxy attended most of these meetings.

An initial Care Plan was developed addressing the risk of skin breakdown. The Skin at Risk Care plan was revised frequently.

When skin breakdown was first noted, the physician was contacted for orders. The resident was not consistently receptive to assessment and treatment of her skin conditions or to showers to keep her skin clean.

The facility involved other health care professionals involved with this resident's care in her skin treatment plan.

The Administrator stated he attended most of the Care Conferences for the resident and agreed with the nurses' assessment of the concerns and the education they provided the resident and her Health Proxy.

The facility recognized the resident was at risk for skin break down and worked with the resident on allowing nursing staff to check and change her when she was incontinent. The facility provided appropriate education to the resident and Health Proxy when the resident was not consistently receptive to care. The facility documented they provided skin care treatment per physician's orders and consulted with other providers. No deficient practice was cited.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

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As none of the allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

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

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I D A H O D E P A R T M E N T O F

H E A L T H & W E L F A R E

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September 16, 2015

James H. Hayes, Administrator
River Ridge Center
640 Filer Avenue West
Twin Falls, ID 83301-4533

Provider #: 135106

Dear Mr. Hayes:

On **August 14, 2015**, an unannounced on-site complaint survey was conducted at River Ridge Center. This complaint was investigated in conjunction with the facility's recertification survey.

During the complaint investigation:

- The identified resident's closed medical records were reviewed as well as facility policies and procedures, grievance logs and Resident Council Minutes. In addition, four additional sampled residents were reviewed for wound care, infection control, weight loss and antibiotic treatment.
- Observations of wound care, incontinent care and nutritional intake occurred throughout the survey.
- Interviews were conducted with nursing staff, social services and administrative staff regarding the issues specific to the complaint.

The complaint allegations, findings and conclusions are as follows:

Complaint #6994

ALLEGATION #1:

After a resident was admitted to the facility, the resident's surgical site became infected and required a second surgery. The facility failed to notify the physician of the change in condition in the resident's incision and did not provide adequate care.

FINDINGS #1:

The identified resident was admitted to the facility after back surgery. The resident was admitted with a 14.5-centimeter incision and orders to apply a dressing, cover it with a dry dressing and change it every other day and as needed.

Nursing notes documented the condition of the wound site on multiple occasions after admission. Each entry documented there was no increased drainage or signs and symptoms of infection. Approximately a month after admission, nurses' notes documented there was a change in the incision site, with minimal leaking and a small opening mid incision. Nurses' notes documented there was no redness or swelling, odor, warmth or increased pain. Nursing staff notified the resident's surgeon at that time and were instructed to continue monitoring for worsening symptoms or new symptoms and notify the surgeon of the same. Nursing notes continued to document dressing changes and the appearance of the incision.

Activities of Daily Living Sheets, during the residents stay, documented the resident had a catheter for a time and experienced increased incontinence when the catheter was removed and was changed as needed each shift. No incidences of the wound dressing being saturated with urine or stool were documented in the nursing notes.

After the above symptoms were noted, the resident visited the surgeon's office on a weekly basis. Initially, physician visit notes documented the incision was not completely healed, had no signs of infection, no significant drainage but leaking some clear drainage. Orders were implemented to increase dressing changes and initiate antibiotic therapy. Shortly thereafter, the resident was scheduled for further surgery.

The surgical report documented a moderate amount of superficial serous drainage, which was non-purulent and had no odor. Both deep and superficial cultures were taken. No antibiotics were ordered. During the surgery, a bony prominence was discovered protruding through the connective tissue of the wound. The bone was removed during the procedure. A device was placed into the wound to facilitate drainage and a vacuum was placed on the incision.

The facility recognized and responded to changes in the condition of the resident's wound, including notifying the resident's surgeon and following new orders for monitoring and dressing changes. There is no evidence the facility allowed the resident's incision to become saturated

with urine or bowel and there was no documentation from the surgeon that the cause of the increased drainage was infection. No deficiency was cited.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

Hospital did not discharge resident with treatment orders, and the facility did not follow-up with the hospital to obtain orders for antibiotic treatment.

Antibiotics for treatment of the infection did not arrive at facility until the day of the resident's death.

FINDINGS #2:

Readmission orders from the hospital included; changing the dressing every other day or as needed and that the resident would need intravenous antibiotics based on culture results.

Final results of the culture were documented by the hospital lab three days after the resident was readmitted and faxed to the facility on the following day. Facility nurses already placed a call to the surgeon because the incision had an increased amount of drainage and the resident's temperature was elevated. The surgeon did not return the call.

Facility nurses placed a call to the surgeon the following day regarding a change in the resident's level of consciousness, the increased wound drainage and report the culture results. The surgeon did not return the call to the facility by that evening and the resident's primary care physician was notified. The primary care physician visited the resident that evening and ordered the resident's morphine be held to determine if it was affecting her level of consciousness. The primary care physician ordered intravenous fluids.

During an interview, the resident's primary care physician stated he was called to the facility because the resident's surgeon had not returned calls to the nurses. The primary care physician stated he called the surgeon also and finally received a return call on the third attempt. The primary care physician stated he was not as concerned with the culture results as he was with the resident's sluggishness and change in level of consciousness. He felt the resident was over medicated at that point, as the wound did not appear infected. When the surgeon returned the call to the facility, the resident was placed on an intravenous antibiotic.

Once the final culture results were faxed to the facility, nurses attempted to contact the resident's surgeon. The resident's surgeon did not return calls to the nurses and the resident's primary care

physician became involved and tried to reach the surgeon. No deficient practice was cited regarding follow-up on the antibiotic therapy. However, during the investigation, it was determined the facility failed to obtain orders for maintenance and care of the peripherally inserted central catheter used to administer intravenous fluids and medications. The facility was cited for deficient practice at F309 on the Federal Survey report.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #3:

The facility failed to identify on one occasion (no date provided) that the resident's clothing was saturated with the drainage from her wound and assistance had to be requested.

FINDINGS #3:

Nursing Notes throughout the resident's stay consistently documented the resident was turned every two hours and checked every two hours for incontinence when out of bed. This frequency of checking would provide consistent opportunities for staff to observe an increase in drainage from the wound on the resident's back. Facility nurses documented on two occasions the dressing was totally saturated with drainage and was changed. On other occasions, the dressing was only moderately to minimally saturated. Based on the medical records deficient practice could not be determined.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

The facility failed to provide services to prevent the resident's wound from becoming infected, which resulted in increased pain, weight loss and a general decline in condition.

FINDINGS #4:

The facility's practices to prevent and respond to signs of infection are addressed under Allegations # 1, 2 and 3.

The resident lost 15 pounds in a three-month period, which was consistent with fluid loss as her pitting edema resolved. During this time, the facility offered additional calories to her meals, snacks and supplements.

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Nurses Notes documented the resident was medicated with long acting Morphine, twice a day, until it was held due to the resident being lethargic and unable to keep her eyes open and/or talking in sentences. During the time she received the Morphine, she requested medications for breakthrough pain one time. During the time the Morphine was held, the resident received crushed Percocet for pain. When nursing staff asked the resident if she was having pain the resident generally answered no and showed no signs of pain. The medical record did not indicate that the resident was in constant pain or suffered from unresolved pain. No deficient practice was cited.

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,

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

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September 18, 2015

James Hayes, Administrator
River Ridge Center
640 Filer Avenue West
Twin Falls, ID 83301-4533

Provider #: 135106

Dear Mr. Hayes:

On **August 14, 2015**, an unannounced on-site complaint survey was conducted at River Ridge Center. This complaint was investigated in conjunction with the facility's recertification survey.

During the complaint investigation:

1. The identified resident's medical records were reviewed as well as facility policies and procedures, grievance logs and Resident Council Minutes.
2. Four sampled residents were reviewed for pain control, adequate hydration, receiving meals they ordered/wanted, call light and dignity issues, and the facility's response to complaints and concerns.
2. Observations were made throughout the survey of the amount of time it took staff to answer call lights, room and bed cleanliness and housekeeping, fresh water kept at residents' bedsides and refreshed routinely, and staff treatment of residents.
3. Interviews were conducted with residents, nursing staff, social services, and administrative staff regarding the issues specific to the complaint.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007128

ALLEGATION #1:

Resident was without pain medications for 12 hours after she was admitted to the facility.

FINDINGS:

The identified resident was admitted to the facility late in the afternoon following right ankle surgery at a local hospital. The resident's transfer orders included both routine and as needed opiate pain medications, as well as an as needed medication for muscle spasms.

Nurses Notes and Medication Administration Records (MARS) for the date of admission documented the resident stated her pain was controlled at that time. The resident received a regularly scheduled dose of pain medication approximately three hours after admission. No complaints of pain or requests for breakthrough pain medication were documented.

The following day Nurses Notes documented no complaints of pain or discomfort noted through the night, but severe pain in the morning. She was medicated with routine and as needed pain medication, which she reported as effective. Later that day, the resident again reported breakthrough pain, and was medicated with adequate relief reported.

The Nurses Notes and medication record documented the resident continued to use as needed pain medication over the next three days. The resident was then evaluated by her physician, and pain medication adjustments made based on her pattern over the previous days.

The facility administered the resident's pain medication as ordered, and there was no documentation of medications not being available. No deficiency was cited.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

Facility did not provide resident with anything to drink for 12 hours after admission. The resident was only given some water to drink when the nurse gave her the 1st pain medications.

FINDINGS:

The facility monitored the resident's fluid intake on the day of her admission. The resident was admitted in the late afternoon, and her record documented consumed fluids with dinner, and again at bedtime.

James Hayes, Administrator
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When interviewed, direct care staff in the facility stated that upon admission, they would help a new resident unpack, orient them to the room, and if allowed by the physician, provide them with a container of ice water.

Bedside tables were checked throughout the survey for ice water and aides were observed passing ice water on each shift.

No deficient practice was cited.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

3. Resident stated she had no food provided to her for at least 2 days when she was first admitted.

FINDINGS:

The resident was admitted to the facility late in the afternoon. The clinical record documented the resident ate dinner that evening, had a snack at bedtime, and had breakfast, lunch, and dinner thereafter throughout her stay. The record documented the resident usually ate well, but did refuse two meals several days after she was admitted.

Nurses notes throughout the resident's stay documented the resident ate independently, usually took meals in the room, and had no difficulty swallowing.

No deficient practice was cited.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

On April 16th or 17th at approximately 6 to 8 AM, it took facility staff greater than 40 minutes to answer the resident's call light. This caused the resident to become incontinent and lay in urine.

FINDINGS:

The resident's medical record was reviewed, and no instances of incontinence were noted.

James Hayes, Administrator
September 18, 2015
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Resident Council Meeting Minutes for six months prior to the survey did not document ongoing issues with call light response times.

Residents attending the group meeting during survey stated their call lights were answered in a timely manner and they were generally not kept waiting.

There was insufficient evidence to cite the facility for non-compliance in answering the resident's call light.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #5:

Resident was put to bed at night in just a T-shirt. The resident had become a hoyer lift at the facility and the staff told the resident, "It's easier this way."

FINDINGS:

The resident's medical record documented initially that one person assisting with transfers was sufficient. However, the record documented the resident would attempt to transfer and ambulate without maintaining weight bearing restrictions related to her recent surgery, and required reminders from staff.

As those restrictions were lifted, the resident continued to increase her independence with ambulation throughout her stay. By her discharge date could totally independently transfer, toilet, dress and undress.

The resident's record did not document that she required a hoyer lift at any time nor did the physical therapist or physician order a Hoyer lift. There is not sufficient evidence to substantiate the complaint.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #6:

Facility failed to clean an identified resident's bed for over 12 hours after it was soiled.

James Hayes, Administrator
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FINDINGS:

The resident's medical record documented no incidents of incontinence of urine or bowel during the specified time of the complaint.

During an interview, the Housekeeping/Laundry Manager stated nursing staff were generally responsible for changing linen on a soiled bed. Housekeeping would be called in if the bed frame or surrounding furniture were soiled as well. The manager stated he was not aware of any instance where a resident's bed was not cleaned/changed for twelve hours after soiling.

Resident Council Minutes listed no complaints of linens not being changed and rooms not cleaned.

Residents interviewed one on one, and a group meeting was held with the residents during survey, and residents stated they had no concerns with housekeeping or laundry issues or with their beds linens not being changed if they needed to be changed.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #7:

Failed failed to provide the resident with the opportunity to pre-choose her meals until 3 weeks after admission.

FINDINGS:

Based on staff interviews and record review, it was determined the facility failed to ensure all residents, who desired to participate in the facility's Menu Choice plan, were provided the opportunity to do so in a timely manner. Please refer to F 242 on the Federal Deficiency Report form 2567.

CONCLUSIONS:

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.

James Hayes, Administrator
September 18, 2015
Page 6 of 6

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 cursive script that reads "Nina Sanderson LSW". The signature is written in black ink and is positioned below the word "Sincerely,".

Nina Sanderson, L.S.W., Supervisor
Long Term Care

NS/lj