



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
FAX: (208) 364-1838
E-mail: fsb@dhw.idaho.gov

October 22, 2015

Dallas Clinger, Administrator
Power County Nursing Home
PO Box 420
American Falls, ID 83211-0420

Provider #: 135066

Dear Mr. Clinger:

On **October 9, 2015**, a survey was conducted at Power County Nursing Home 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.**

FILE COPY

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 **November 4, 2015**. Failure to submit an acceptable PoC by **November 4, 2015**, may result in the imposition of civil monetary penalties by **November 24, 2015**.

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

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

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

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

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

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **November 26, 2015 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **November 26, 2015**. A change in the seriousness of the deficiencies on **November 26, 2015**, may result in a change in the remedy.

Dallas Clinger, Administrator
October 22, 2015
Page 3 of 4

The remedy, which will be recommended if substantial compliance has not been achieved by **November 26, 2015** includes the following:

Denial of payment for new admissions effective **January 9, 2016**. [42 CFR §488.417(a)]

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

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **April 9, 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 **October 9, 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>

Dallas Clinger, Administrator
October 22, 2015
Page 4 of 4

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

- BFS Letters (06/30/11)

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

This request must be received by **November 4, 2015**. If your request for informal dispute resolution is received after **November 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, Supervisor
Long Term Care

NS/lj
Enclosures

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

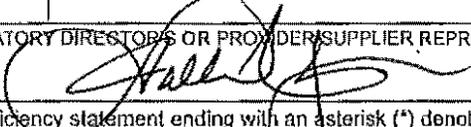
PRINTED: 10/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135066	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/09/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER POWER COUNTY NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 510 ROOSEVELT STREET (83211-1382) AMERICAN FALLS, ID 83211
---	--

(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	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the federal recertification and complaint survey conducted at the facility from October 5 to October 9, 2015.</p> <p>The surveyors conducting the survey were: Linda Hukill-Neil, RN, Team Coordinator Linda Kelly, RN Presie Billington, RN Angela Morgan, RN, BSN</p> <p>Survey Definitions: ADL = Activities of Daily Living CNA = Certified Nurse Aide COPD = Chronic Obstructive Pulmonary Disorder DON = Director of Nursing IV = Intravenous LN = Licensed Nurse MAR = Medication Administration Record mcg = micrograms O2 = Oxygen PRN = As Needed TAR = Treatment Administration Record</p>	F 000	<p>F000</p> <p>The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible evidence and request a desk review in lieu of post re-certification on or after 11/4/2015.</p> <p>RECEIVED NOV - 6 2015 FACILITY STANDARDS</p>	
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</p>	F 280	<p>F280 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>Residents with potential to be affected: All residents have the potential to be affected.</p> <p>Corrective Actions: For resident #1, supplements and specific food preferences were added to her care plan including ice cream. Resident #5's brace was to be used PRN, it was removed from</p>	04NOV15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE CEO / ADMINISTRATOR	(X6) DATE 4 NOV 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.

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

PRINTED: 10/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135066	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/09/2015	
NAME OF PROVIDER OR SUPPLIER POWER COUNTY NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 510 ROOSEVELT STREET (83211-1362) AMERICAN FALLS, ID 83211		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	<p>Continued From page 1</p> <p>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 resident and staff interview, it was determined the facility failed to revise care plans for 2 of 9 (#'s 1 & 5) sampled residents. Resident #1's care plan was not revised to include the resident was receiving nutritional supplements, extra protein and ice cream. Resident #5's care plan did not include direction to use a left knee brace. The deficient practice 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 #1 was admitted to the facility with multiple diagnoses including dementia.</p> <p>Review of the Nutrition Notes documented the following interventions: *On 5/25/15 the facility began providing high calorie supplements three times daily (TID) *On 8/27/15 the facility began serving extra protein and ice cream at lunch and dinner</p> <p>The residents dietary meal card noted the interventions to provide a 4 oz supplement with meals, extra protein and vanilla ice cream with</p>	F 280	<p>the care plan per non-use and refusal to wear by the resident.</p> <p>All resident care plans were reviewed for any equipment needs and instructions to be added. Resident diet cards were also reviewed for accuracy to update on the resident care plans.</p> <p><u>Measures to Prevent Recurrence:</u> All resident care plans will be reviewed at least quarterly and with significant condition changes by the IDT team consisting of Dietary, Social Services, Activities, and the DON or designee. An RN will also review resident charts weekly for new orders and needed updates to the care plan. IDT meetings will also include a review of resident equipment and supplement needs and instructions to be included on the care plans. The Dietary Manager will notify the MDS Nurse and DON via email with diet additions or changes to resident supplements, recommendations and preferences. The MDS Nurse will place specific directions on the care plan regarding specialized diets and supplements. These diet changes will be reviewed and checked at the weekly IDT and Stand-up meetings.</p> <p><u>Monitoring/Assurance:</u> Each Sunday an RN will complete an audit of the resident charts and care plans. The audit will be turned into the DON for review each Monday. This audit will begin 11/2/2015 and will be done once a week for six weeks, then twice a month for two</p>	

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

PRINTED: 10/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135066	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/09/2015
NAME OF PROVIDER OR SUPPLIER POWER COUNTY NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 510 ROOSEVELT STREET (83211-1362) AMERICAN FALLS, ID 83211		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 280	Continued From page 2 lunch and dinner meals. On 10/9/15 at 8:20 AM, the Dietary Manager (DM) was asked if the interventions to give nutritional supplements, extra protein, ice cream and weekly weights should be on the resident's care plan. The DM said the interventions were previously on the resident's care plan but the items dropped off. On 10/9/15 at 12:30 PM, the DON said the above interventions should be on the resident's care plan. 2. Resident #5 was admitted to the facility with multiple diagnoses including osteoarthritis. Review of Resident's record documented a Physician's Order for a left knee brace initiated on 1/30/15. The resident's care plan did not documentation direction to use the left knee brace. On 10/9/15 at 12:30 PM, the DON said the brace should be on the care plan.	F 280	months, and monthly thereafter. Any discrepancies will be discussed at the Interdisciplinary Team meetings.		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.	F 314	F314 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES <u>Residents with potential to be affected:</u> All residents have the potential to be affected.	04NOV15	

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

PRINTED: 10/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135066	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/09/2015
NAME OF PROVIDER OR SUPPLIER POWER COUNTY NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 510 ROOSEVELT STREET (83211-1362) AMERICAN FALLS, ID 83211		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 314	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review it was determined the facility failed to ensure comprehensive assessments of an existing pressure ulcer (PU) were completed for 1 of 2 residents (#2) reviewed for PU. The failure created the potential for harm if Resident #2's PU increased in size or worsened. Findings included: Resident #2 was admitted on 2/11/14 with an existing stage 4 PU and readmitted on 6/2/14 and 7/8/14 with multiple diagnoses that included chronic stage 4 PU, Chronic Kidney Disease and Cauda Equina Syndrome. The most recent Quarterly MDS assessment, dated 9/11/15, documented the resident was cognitively intact with a BIMS score of 15, stage 4 PU and frequent bladder incontinence. The PU CAA dated 6/11/15 documented an "unhealed ulcer which is closing slowly." The resident's PU Care Plan included staff assistance with toileting, wound care, dressing changes, keep PU covered with non-adhesive dressing at all times and encourage position changes. On 10/7/15 at 3:50 pm, LN #3 was observed to performed wound care and dressing change to the resident ' s PU. The LN did not measure the PU. Bathing Skin Check records, dated 2/14/15 to 10/3/15, documented the location of the PU as a "coccyx sore, sacral woun" or "open area coccyx." The sacral/coccyx area was circled on the posterior aspect of a body diagram. The documentation did not include the stage, size, presence/absence of exudate and odor, or the	F 314	<u>Corrective Actions:</u> Resident #2 is no longer attending the wound clinic as the physician has deemed the facility is able to meet the resident's needs and complete the required assessments and interventions. The facility wound nurse will continue to assess resident #2's wound each week with complete measurements and description and communication of any changes in treatment needs to the physician. All other LN's will follow the prescribed treatments and report worsening or changes in the wound throughout the week to the wound nurse. All residents will continue to receive a weekly skin assessment by the skin/wound nurse. The nurse will document findings in the EMR and complete a nursing note in detail for any wound or significant skin condition and will monitor treatment of those identified conditions. Further skin assessments will be completed weekly by the LN with CNA staff instructed to report changes in skin noted during toileting, bathing and hygienic practices. <u>Measures to Prevent Recurrence:</u> The designated skin/wound nurse will perform a complete skin assessment weekly at the beginning of each week for all residents. Assessments will include entry in the EMR for the skin assessment and a detailed nursing note of the assessment, which will include, but is not limited to the following: wound bed, odor, size, depth,		

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

PRINTED: 10/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135066	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/09/2015
NAME OF PROVIDER OR SUPPLIER POWER COUNTY NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 510 ROOSEVELT STREET (83211-1362) AMERICAN FALLS, ID 83211		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	<p>Continued From page 4</p> <p>characteristics of the wound bed/edges and surrounding tissue. The frequency of the Bathing Skin Checks varied from 2 days to 36 days. Four Skin Observation Tools in March 2015 documented the coccyx PU was "evaluated" "staged" and "treated" at the wound clinic. The documentation did not consistently include the stage of the PU. None of the Skin Observation Tools documented the size, presence/absence of exudate and odor, or the characteristics of the wound bed/edges and surrounding tissue. The facility did not provide any other Skin Observation Tools.</p> <p>Review of the wound clinic documentation revealed the resident was seen every 2-3 weeks from 1/14/15 to 6/2/15 and every four weeks from 6/2/15 to 9/2/15 with comprehensive assessment of the pressure ulcer completed at each visit.</p> <p>On 10/9/15 at 10:08 am the DON was asked if the facility performed comprehensive assessments of the resident's PU. The DON said that facility LNs monitored the PU and that comprehensive assessments were done by the wound clinic.</p> <p>There was no documented evidence the facility completed comprehensive assessments of the resident's PU in between the wound clinic assessments.</p>	F 314	<p>drainage/ exudate, color, surrounding tissue, and treatment.</p> <p>The LN and CNA staff will also performed skin checks as assigned and report any new findings or changes to the charge nurse daily. The charge nurse will notify the wound nurse.</p> <p><u>Monitoring/Assurance:</u> The DON will receive a printed copy of all wound assessments and report from the wound nurse weekly. The DON or designee will review the weekly report and ensure proper documentation is being performed and wounds are being monitored and treated. This audit will begin the week of 11/02/2015 and will be done once a week for six weeks, then twice a month for two months, and then once a month thereafter. Any discrepancies will be reviewed at the Interdisciplinary Team meetings.</p>	
F 323 SS=E	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to</p>	F 323	<p>F323 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p><u>Residents with potential to be affected:</u> All residents have the potential to be affected.</p>	04NOV15

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

PRINTED: 10/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135066	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/09/2015
NAME OF PROVIDER OR SUPPLIER POWER COUNTY NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 510 ROOSEVELT STREET (83211-1362) AMERICAN FALLS, ID 83211		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	<p>Continued From page 5 prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure harmful chemicals were securely stored and inaccessible to residents. This was true for 2 of 8 sampled residents (#2 and #6) and all independently mobile and cognitively impaired residents who may encounter the chemicals. Failure to safely store harmful chemicals created the potential for residents to experience skin, respiratory tract and gastric irritation. Findings included:</p> <p>1. On 10/05/15 at 12:50 pm, the Janitor Room was observed to be unlocked and inside were found the following chemicals:</p> <p>*1 quart Tropical Mist Air Deodorizer spray bottle - "Causes eye irritation, flammable. "</p> <p>*1 full spray bottle of Non Acid Bowl and Bathroom Disinfectant Cleaner - "Causes severe skin burns and serious eye damage."</p> <p>*1 full 3.78 quart bottle of Clorox found on the floor - "Causes moderate eye irritation. Avoid contact with eyes or clothing."</p> <p>*1 full unmarked bottle with an unknown liquid.</p> <p>*1 quart of Hydrogen Peroxide Cleaner Disinfectant, nozzle on - "Keep out of reach of children. Avoid contact with eyes and clothing."</p>	F 323	<p><u>Corrective Actions:</u> The janitor closet door was re-locked after the surveyors observed the door to be unlocked. The door knob was updated on 11/4/2015 with an auto-lock function that can only be unlocked with a key that all housekeepers, housekeeping supervisor, maintenance staff, and nursing staff have. All chemicals and wipes used to clean hard surfaces are locked in the janitor closet and are not being left unattended.</p> <p><u>Measures to Prevent Recurrence:</u> The Administrator or designee will conduct checks to ensure that the janitor closet doors are properly locked. The Administrator or designee will also conduct checks to ensure that all chemicals and wipes used to clean hard surfaces are not left unattended and are stored correctly. An in-service was held 11/3/2015 to review with housekeeping staff the importance of securing all janitor closet doors using the key to lock it and to not leave chemicals and wipes unattended.</p> <p><u>Monitoring/Assurance:</u> The Administrator or designee will monitor that the janitor closet doors are properly locked and that all chemicals and wipes used to clean hard surfaces are not left unattended and are stored correctly. This audit will begin the week of 11/2/2015 and will be done once weekly for four weeks, then</p>		

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

PRINTED: 10/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135066	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/09/2015
NAME OF PROVIDER OR SUPPLIER POWER COUNTY NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 510 ROOSEVELT STREET (83211-1362) AMERICAN FALLS, ID 83211		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	<p>Continued From page 6</p> <p>*1 quart of Crew Heavy Duty Cleaner- "Danger Poison, Hazard to humans and domestic animals. Corrosive, maybe fatal if swallowed."</p> <p>*1 full bottle of Multi Surface Crème Cleanser- "Caution: causes eye and skin irritation."</p> <p>*1 full spray bottle of Triad Disinfectant Cleaner- "Causes burns/serious damage to mouth, throat and stomach. Avoid contact with eyes, skin and clothing."</p> <p>On 10/5/15 at 1:05 pm, CNA #9 who was in the vicinity was asked about the unlocked Janitor room. The CNA said "It should always be locked." The CNA locked the Janitor room door by pressing the locking mechanism on the inside of the door. However the door opened again when the surveyor turned the outside of the knob.</p> <p>On 10/5/15 at 1:10 pm, the DON arrived at the hallway by the Janitor's room and was informed of the unlock Janitor's room with unsecured chemicals. CNA #9 said she would request a work order for the door right away.</p> <p>On 10/05/15 at 1:25 pm, Housekeeper #5 was seen entering the Janitor room using a key. She said a key was needed to lock and unlock the door and that nurses also had a key to the room.</p> <p>2. On 10/05/15 at 1:05 pm, A container of Hydrogen Peroxide Disinfectant Wipes "causes moderate eye irritation" was found unattended on top of the chart cart in the nurse station.</p> <p>On 10/5/15 at 1:10 pm, the DON was shown the unsecured container of wipes at the nurse's station. The DON removed the container from the</p>	F 323	monthly for five months. Any discrepancies will be discussed with the Quality Assurance Committee.	

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

PRINTED: 10/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135066	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/09/2015
NAME OF PROVIDER OR SUPPLIER POWER COUNTY NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 510 ROOSEVELT STREET (83211-1362) AMERICAN FALLS, ID 83211	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 7 nurse's station. 3. On 10/5/15 at 4:00 pm, 1 container of Hydrogen Peroxide Disinfectant wipes was observed on the counter by the sink in the room where Residents #2 and #6 reside. On 10/5/15 at 4:07 pm, the DON accompanied two surveyors to Residents #2 and #6's room and was shown the unsecured container of wipes. The DON removed the container from the room. 4. On 10/06/15 at 8:40 am, two containers of Hydrogen Peroxide Disinfectant Cleaner were found on the shelf above the sink in the Family Room. On 10/06/15 at 9:17 am, the DON accompanied two surveyors to the Family room. The DON was shown the two unsecured containers of Hydrogen Peroxide Disinfectant Cleaner. He said the containers should be behind the nurse's station inside the cabinet. He removed the two containers from the Family room.	F 323		
F 329 SS=D	483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a	F 329	F329 483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS <u>Residents with potential to be affected:</u> All residents have the potential to be affected. <u>Corrective Actions:</u> Resident #1's melatonin has been discontinued. A copy of all resident orders was sent to the MDS nurse who enters and tracks all medications on the monthly recaps.	04NOV15

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

PRINTED: 10/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135066	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/09/2015
NAME OF PROVIDER OR SUPPLIER POWER COUNTY NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 510 ROOSEVELT STREET (83211-1362) AMERICAN FALLS, ID 83211		
(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 329	<p>Continued From page 8</p> <p>resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to ensure clinically relevant rationale for the use of anti-psychotic medications, and evaluation of the effectiveness of medications to treat behavioral symptoms and promote sleep. This was true for 1 of 9 (#1) residents reviewed for psychotropic medications. This failed practice created the potential for harm if unnecessary medications lead to adverse reactions and health decline. Findings included: Resident #1 was admitted to the facility on 2/17/05 and had diagnoses which included paranoid state and senile dementia with depressive features. The resident's Annual MDS CAA worksheet Psychotropic Drug Use dated 12/11/14 documented, "Not on any anxiolytics (anxiety medications) but did have an increase in her Risperdal on 9/2/14 which we have since requested to be decreased. She started having increased sedation, confusion and urinary incontinence which staff believe is partially related</p>	F 329	<p>Identification of any hypnotics was reviewed and sleep monitoring added to resident care plans and the MAR if needed. Staff training was distributed on 10/28/2015 to review the documentation process for resident behaviors and appropriate interventions.</p> <p><u>Measures to Prevent Recurrence:</u> The MDS nurse and the LSW will continue to review the use of psychotropic medications with orders and behavior documentation. Resident recaps and behavior monitoring logs will also continue to be checked monthly along with complete diagnoses at the Pharmacy Review meeting. An RN will review the weekly orders each Sunday to see that they are complete and documented on the care plan and MAR/TAR and submit a written report to the DON of findings and corrections for Monday review. The Pharmacy Tech will facilitate a more comprehensive medication review with the Pharmacist by providing prompts to the Pharmacist for possible drug interactions, contraindications, duplicative therapy, drug warnings, special instructions, and appropriateness diagnoses. These will be added to the Physician Action Report and placed on the MAR as needed with flags for the staff to be aware of.</p> <p><u>Monitoring/Assurance:</u></p>		

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

PRINTED: 10/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135066	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/09/2015
NAME OF PROVIDER OR SUPPLIER POWER COUNTY NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 510 ROOSEVELT STREET (83211-1362) AMERICAN FALLS, ID 83211		
(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 329	<p>Continued From page 9</p> <p>to Risperdal increase. Still waiting for physician response."</p> <p>A Physician Action Report dated 12/10/2014 documented a request to consider a dose reduction for Resident #1's Risperidone from 0.5 mg to 0.25 mg. The physician comment area documented, "Not at this time. Her depression will relapse."</p> <p>The resident's 8/29/15 recapitulated physician's order documented: *Risperidone to 0.5 mg po [by mouth] qd [every day] for paranoia and agitation. with a start date of 9/2/14, *Sertraline 25 mg po daily for depression, start date of 1/28/10, and *Melatonin 5 mg po q hs (at bedtime), start date of 8/17/15 no diagnosis listed.</p> <p>A Physician Action Report dated 8/17/15 documented a request for Melatonin, a medication used to promote sleep, with the rationale, "having behavior issues." The record did not indicate Melatonin is for sleep. Review of the resident's medical record revealed no documentation monitoring the resident's sleep patterns. There was also no care plan initiated for the resident's insomnia.</p> <p>On 10/9/15 at 11:50 AM, the LSW was interviewed about what behaviors were being monitored for Resident #1. The LSW said the resident was having attention seeking behaviors. The LSW provided a Psychotropic Tracking Sheet for June and September 2015 but could not locate the tracking sheets for July and August.</p> <p>On 10/9/15 at 12:30 PM, the DON stated the resident was having hoarding, resistive to cares at night and wandering behaviors. The DON could not explain how the those target behaviors warranted the use of an anti-psychotic medication. The DON said the ordered Melatonin</p>	F 329	The DON or designee will review the RN medication orders report weekly to address issues. This audit will begin 11/02/2015 and will be done once a week for six weeks, then twice a month for two months, then monthly thereafter. Any discrepancies will be reviewed at the weekly IDT meetings and monthly Pharmacy Review meeting.		

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

PRINTED: 10/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135066	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/09/2015
NAME OF PROVIDER OR SUPPLIER POWER COUNTY NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 510 ROOSEVELT STREET (83211-1362) AMERICAN FALLS, ID 83211		
(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 329	Continued From page 10 is for sleep and the hours of sleep should have been monitored.	F 329	F332 483.25(m)(1)	04NOV15	
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. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to maintain a medication error rate of less than 5 percent. This was true for 3 of 25 medications administered (12%), which affected 2 of 8 residents (#s 10 & 11) reviewed for medication administration practices. This failure created the potential for harm if residents received less than optimum benefit or developed oral candidiasis from the prescribed medications. Findings included: 1. Resident #10's October 2015 Physician's Orders and MAR included orders for 1 tablet of Levothyroxine 175 mcg by mouth daily at 7:00 AM and 1 puff of Advair Diskus 500-50 mcg twice daily at 8:00 AM and bedtime. On 10/6/15 at 9:00 AM, LN #1 was observed to administer Resident #10's Levothyroxine, right after she had finished her breakfast. The resident's Advair inhaler was administered next and the resident had a medical appointment and was propelled in her wheelchair out to the facility's van, without the resident being offered to rinse her mouth.	F 332	FREE OF MEDICATION ERROR RATES OF 5% OR MORE <u>Residents with potential to be affected:</u> All residents have the potential to be affected. <u>Corrective Actions:</u> Staff members were instructed on 10/20/2015 and 10/28/2015 in-services on the proper administration of thyroid medications and inhalers for resident #10. The time of medication administration was changed for Resident #11 to 7:00 a.m., to accommodate the resident's choice to eat and snack throughout the day. The MARS were reviewed for classes of medications which require administration prior to meals. A request to the Pharmacy was made to highlight all special condition administration and warnings of drugs with the production of the MAR for staff. General staff education was provided on 10/20/2015, 10/28/2015, and 10/29/2015 to follow manufacturer instructions related to times and conditions for medication administration. <u>Measures to Prevent Recurrence:</u> The contracted Pharmacy will provide additional information for heightened awareness of contraindications of medications. The DON or designee will attend the monthly Pharmacy Review		

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

PRINTED: 10/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135066	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/09/2015
NAME OF PROVIDER OR SUPPLIER POWER COUNTY NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 510 ROOSEVELT STREET (83211-1362) AMERICAN FALLS, ID 83211		
(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 332	Continued From page 11 On 10/6/15 at 2:10 PM, the DON was interviewed about the administration of Levothyroxine and the Advair inhaler. The DON stated the LNs should be aware that Levothyroxine needed to be administered 1/2 to 1 hour before a meal and the importance of residents rinsing their mouth after Advair to prevent thrush, even if the Physicians' orders nor the MARs documented this information. 2. Resident #11's October 2015 Physician's Orders and MAR included orders for 1 tablet of Levothyroxine 88 mcg by mouth daily at noon. On 10/8/15 at 11:25 AM, Resident #11 was in her room and seated at the edge of the bed. The resident had a breakfast meal tray in front of her and was eating. LN #2 was observed to administer Resident #11's Levothyroxine. The LN left the room and while she walked down the hallway stated she knew the Levothyroxine was to be administered prior to a meal, but the resident ate on and off all day and so she would inform the Physician and ask for recommendations.	F 332	meeting to ensure that the Pharmacist addresses significant risk factors of associated medications and offers recommendations as needed. The LN's also reviewed in-service material provided on 10/28/2015 and 10/29/2015 for food and drug interactions and drug classes and will follow manufacture recommendation for medication administration. <u>Monitoring/Assurance:</u> An RN will perform audits to determine compliance with staff medication administration per manufacturer recommendations with the med pass. This audit will begin 11/2/2015 and will be done twice a week for two weeks, then once a week for four weeks, then twice a month for two months. Any discrepancies will be discussed at the weekly Stand-up meetings and monthly Pharmacy Review meetings.		
F 372 SS=C	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure the outside trash containers were in good condition. This created a potential for rodents and bugs to be	F 372	F372 483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY <u>Residents with potential to be affected:</u> All residents have the potential to be affected.	04NOV15	

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

PRINTED: 10/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135066	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/09/2015
NAME OF PROVIDER OR SUPPLIER POWER COUNTY NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 510 ROOSEVELT STREET (83211-1362) AMERICAN FALLS, ID 83211		
(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 372	Continued From page 12 attracted and to enter the trash containers which could affect sampled residents #s 1-7 and #9 as well as all other residents living in the facility. Finding included: On 10/08/15 at 2:15 pm, during the environmental tour of the facility with the Maintenance Supervisor (MS), two of the four big black trash containers located at the front of the facility were observed with a hole on the front. The hole on one of the trash containers was 4 inches by 2 inches and the hole on the second trash container was 4 inches by 5 inches as measured by MS. The MS said the holes were caused by the clamp used by the garbage collector to pick up the containers. The MS said he would call the City department to request new trash containers.	F 372	<u>Corrective Actions:</u> The maintenance staff contacted the city sanitation department and asked them to replace the outside garbage cans with the holes in them. On 10/12/2015 two of the cans were replaced with new ones and the other two cans were patched and sealed by the city. <u>Measures to Prevent Recurrence:</u> The maintenance staff will continue to do a weekly walk through of the grounds and will visually inspect the cans for damage or punctures. Any findings will be addressed by the maintenance staff for repair and logged in the maintenance binder with the weekly inspections.		
F 385 SS=D	483.40(a) RESIDENTS' CARE SUPERVISED BY A PHYSICIAN A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. The facility must ensure that the medical care of each resident is supervised by a physician; and another physician supervises the medical care of residents when their attending physician is unavailable. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure the physician responded with an order to transport a resident to the hospital, who was in respiratory	F 385	<u>Monitoring/Assurance:</u> The Maintenance Manager will inspect all garbage cans weekly, and on the first sight of damage the city will be called to replace the cans. This audit will begin on 11/2/2015 and will be done weekly with the facility grounds walk-through inspection. Any discrepancies will be reviewed at the monthly Quality Assurance Committee meeting.		

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

PRINTED: 10/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135066	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/09/2015
NAME OF PROVIDER OR SUPPLIER POWER COUNTY NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 510 ROOSEVELT STREET (83211-1362) AMERICAN FALLS, ID 83211		
(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 385	<p>Continued From page 13</p> <p>distress. This was true for 1 of 9 sampled residents (#9). The deficient practice had the potential to cause harm when a resident had aspirated on food and the physician had failed to honor the resident's advance directive for emergent care when needed. The physician would not provide an order to transport, even though the resident continued to experience signs and symptoms of respiratory distress. Findings included:</p> <p>Resident #9 was admitted to the facility on 8/30/13 and readmitted on 5/27/15, with multiple diagnoses which included Lewy body dementia with hallucinations and agitation.</p> <p>The resident had an Idaho Physician Orders for Scope of Treatment (POST), dated 2/8/12, which documented the resident was a DNR (Do Not Resuscitate) and limited additional interventions which included cardiac monitoring, oral/IV medications, transfer to a hospital if indicated, no intubation or advanced airway interventions, and no admittance to Intensive Care.</p> <p>Resident #9's medical record contained a document titled, Plan for Emergency Care and Intensity of Treatment, signed by the Power of Attorney (POA) on 11/15/14. It documented the resident was to be transferred to the hospital for necessary treatment and intervention to be discussed with resident/patient and/or surrogate decision maker.</p> <p>The following information was gathered for Resident #9 from Physician's Orders (PO), local Emergency Room/Nurse Practitioner (ER/NP) Note, Nursing Progress Notes (NN), Licensed Social Worker Note (LSWN), and Hospital</p>	F 385	<p>F 385 483.40(a)</p> <p>RESIDENTS' CARE SUPERVISED BY A PHYSICIAN</p> <p><u>Residents with potential to be affected:</u> All residents have the potential to be affected.</p> <p><u>Corrective Actions:</u> The Administrator has provided a copy of the state citations and discrepancies and spoke with all resident physicians by 10/30/2015, with reminders about the Physician Orders for Scope of Treatment (POST) and the necessity of following the wishes of the resident and/or surrogate decision maker. The Administrator also spoke with the facility's Medical Director on 10/30/2015, and reminded him that he should make the decision and order care if the resident's primary physician is unavailable or fails to follow the POST or the wishes of the resident and/or surrogate decision maker. A follow-up letter was also sent by the Administrator on 11/3/2015 to all physicians reviewing the requirements for resident advanced directives and orders.</p> <p><u>Measures to Prevent Recurrence:</u> On 11/3/2015, the Administrator issued a memo (see attached) to the entire Long Term Care nursing staff to contact him</p>	04NOV15	

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

PRINTED: 10/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135066	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/09/2015	
NAME OF PROVIDER OR SUPPLIER POWER COUNTY NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 510 ROOSEVELT STREET (83211-1362) AMERICAN FALLS, ID 83211		
(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 385	<p>Continued From page 14</p> <p>Discharge Summary (HDS):</p> <p>*4/17/15 (NN) 1:24 PM - "Resident was eating cake with a mandarin orange slice on top and sneezed and appeared to choke on it. Did not need to do Heimlich, resident coughed and had some trouble catching her breath, started to have large amounts of sputum, suctioned per RN. Tried to call her doctor, unable to reach, sent him a fax to notify him and to tell him we may have her go through the ER. Called and told POA what happened and the POA stated it was ok for the resident to be seen in the ER. The resident was taken to the ER."</p> <p>*4/17/15 (ER/NP) 1:30 PM - "Resident in ER with chief complaint of choking on an orange. Room air on admit was 82%. Supplemental O2 (oxygen) given to keep saturations greater than 90%. Loose cough, suctioning provided, patient will not spit out her mucous. Chest x-ray showed good lung capacity and no foreign bodies. No obvious pneumonia at this time. Monitored patient for approximately an hour with no respiratory distress noted. Discharged from ER at 2:25 PM to Skilled Nursing Facility in stable condition at that time. Return to the ER if any concerns."</p> <p>*4/17/15 (NN) 2:23 PM - "Report received from ER nurse and states the resident's lungs are clear, keep head of bed up at least 30 degrees, monitor for aspiration pneumonia, and keep suction nearby."</p> <p>*4/17/15 (NN) 4:03 PM - "O2 saturation 75%, suctioned thick secretions, did not help much, put oxygen on resident, will try to call MD again."</p> <p>*4/17/15 (NN) 4:34 PM - "O2 saturation 90% on 4 liters. Called MD, ordered O2 at whatever rate keeps saturation above 89%, Augmentin liquid for prophylaxis, and to make the resident comfortable."</p> <p>*4/17/15 (PO) 4:50 PM - "O2 via nasal cannula</p>	F 385	<p>in the event of a resident's physician not taking action according to the advanced directives of the resident and/or the Medical Director not making orders in the event of the resident's physician absence.</p> <p><u>Monitoring/Assurance:</u> Beginning 11/2/2015, the Administrator will question the long-term care nursing staff and/or Director of Nursing monthly for six months for evidence of physician compliance with resident advanced directives. Any discrepancies will be reviewed at the monthly Quality Assurance Committee meeting.</p>	

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

PRINTED: 10/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135066	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/09/2015
NAME OF PROVIDER OR SUPPLIER POWER COUNTY NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 510 ROOSEVELT STREET (83211-1362) AMERICAN FALLS, ID 83211		
(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 385	Continued From page 15 and titrate to keep saturation greater than 89% as needed. Augmentin two times a day for 8 days. Diagnosis: aspiration and short of breath." This order was signed by the physician on 4/27/15 *4/17/15 (PO) 11:00 PM -"Transport to local ER per interested parties' demands." Physician signed the order on 4/27/15 *4/17/15 (ER) 11:51 PM - "Patient brought to ER by ambulance. She choked on some peaches and since then has developed shortness of breath and hypoxia. O2 saturation was 70's on room air upon arrival. POA and other interested parties are present and tell the ER the resident is full code and was doing fine earlier in the day. Weak cough, non-productive, breath sounds with rhonci to bilateral upper lobes, otherwise diminished, oxygen saturation 93% on 15 LPM via non rebreather." *4/20/15 (LSWN) - "POA notified on 4/17/15 the resident had choked at 1:00 PM and she had xrays and was now being monitored. The POA and other interested parties visited the resident at 8:30 PM, when the resident's O2 saturation was in the 70's. At 10:00 PM the O2 saturation was 83% and staff were still monitoring. The resident was taken to a different ER then was transferred to the Intensive Care Unit. During the hospitalization the resident's O2 level increased and life support was not needed." *4/23/15 (NN) - "On the 17th, I took care of this resident. She continually needed to be monitored for aspiration pneumonia. Suction machine placed by resident and suctioning went on for three hours. Good air exchange both upper lobes and raspy very top of the esophagus. An interested party demanded the resident go to the hospital. Call made to the resident's physician with no answer. Call placed to the Medical Director and who stated to contact the resident's	F 385			

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

PRINTED: 10/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135066	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/09/2015
NAME OF PROVIDER OR SUPPLIER POWER COUNTY NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 510 ROOSEVELT STREET (83211-1362) AMERICAN FALLS, ID 83211		
(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 385	<p>Continued From page 16</p> <p>primary physician. Another nurse contacted the resident's physician. The physician refused to give an order for the resident to be transported to the hospital. The physician was informed the resident's interested party demanded the resident go to the hospital. 911 was called and the resident was transported to a local hospital at 11:00 PM via ambulance. The resident left AMA." *4/24/15 (HDS) - "Admit and Discharge Diagnoses: Sepsis, acute kidney injury, acute on chronic respiratory failure, and aspiration pneumonia. Discharged to home with Home Health."</p> <p>*5/25/15 (NN) - "Resident was not an aspiration risk prior to the aspiration incident. The resident after returning from the local ER was continually assessed. The resident's saturations began to drop and the resident's primary physician was contacted and declined having her go to another hospital's ER."</p> <p>On 10/7/15 at 4:15 PM, the DON was interviewed regarding the resident's aspiration episode on 4/17/15. The DON said the resident's authorized representatives disagreed with the physician's decision not to transfer the resident to an ER The DON said he thought the resident's physician refused to give an ER transport order because of the resident's DNR status.</p> <p>On 10/8/15 at 4:00 PM, LN #10 was interviewed regarding Resident #9's aspiration episode on 4/17/15. The LN stated she had cared for the resident after the incident and at 5:30 to 6:00 PM, the resident had raspy breathe sounds and her color was ashen. The LN said she suctioned the resident and retrieved pieces of orange and chunks of food from the resident's mouth. The LN said she monitored the residents' O2 saturation</p>	F 385		

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

PRINTED: 10/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135066	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/09/2015
NAME OF PROVIDER OR SUPPLIER POWER COUNTY NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 510 ROOSEVELT STREET (83211-1382) AMERICAN FALLS, ID 83211		
(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 385	Continued From page 17 throughout the evening and she was quite concerned about her. The LN stated she knew the resident had a DNR order, but called the physician for a verbal order to send the resident to the ER and the physician said no. The LN said an interested party demanded the resident go to an ER, 911 was called, and the resident was transported by EMS to an ER.	F 385	F387 483.40(c)(1)-(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT <u>Residents with potential to be affected:</u> All residents have the potential to be affected. <u>Corrective Actions:</u> The Administrator has spoken with all resident physicians by 10/29/2015 with reminders about the regulations concerning frequency and timeliness of physician in-person visits every 60 days for current residents and every 30 days for new residents for the first 90 days after admission. Additionally, resident #1 was visited in-person by their physician for follow-up and documentation on 10/29/2015. <u>Measures to Prevent Recurrence:</u> The LSW will conduct monthly checks of resident records to verify timeliness of the physician in-person visits. The LSW will also send reminder notices to physicians, prior to visit due dates, to ensure that residents are seen in-person according to the regulation due dates. The LSW will contact the DON and Administrator for all physician visits that are not completed by the due date. The Administrator will then contact the Medical Director to complete the resident visits within the regulation timeframe.	04NOV15	
F 387 SS=D	483.40(c)(1)-(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview it was determined the facility failed to ensure 1 of 9 (#1) sampled residents received timely physician visits. Resident #1 had not been seen by an MD [Medical Doctor] for approximately five months. Failure to ensure timely physician visits placed the resident at risk to receive unnecessary medications. Findings included: 1. Resident #1 was admitted to the facility on 2/17/05 with multiple diagnoses including CHF. The resident's medical record documented the last MD visited on 5/15/15. Refer to the citation F329 for Unnecessary Drugs.	F 387			

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

PRINTED: 10/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135066	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/09/2015
NAME OF PROVIDER OR SUPPLIER POWER COUNTY NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 510 ROOSEVELT STREET (83211-1362) AMERICAN FALLS, ID 83211		
(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 387	Continued From page 18 On 10/8/15 at 4:30 PM, the DON was informed of the above concern and said the resident was not seen by her physician since 5/15/15. The DON was asked to provide documentation of any physician visits from April to the current day. The DON stated he was attempting to reach the resident's physician but the physician was out of his office this week. No additional documentation was received.	F 387	<u>Monitoring/Assurance:</u> The DON will monitor to check for physician compliance with frequency and timeliness of all resident visits every month and report this to the Administrator. This will begin the week of 11/2/2015 and will be done monthly for one year. Any discrepancies will also be reviewed at the Interdisciplinary Team meetings.		
F 431 SS=D	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. 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. 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. 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	F 431	F431 483.60(b),(d),(e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS <u>Residents with potential to be affected:</u> All residents have the potential to be affected. <u>Corrective Actions:</u> Resident #2 and Resident #6 had the Vashe wound cleanser removed at the time of discovery and tubes of Calmoseptine and Desitin were labeled by staff members and placed in appropriate drawers for safe keeping. <u>Measures to Prevent Recurrence:</u> Training was given to staff on 10/20/2015 and 10/28/2015 to label all items correctly once opened. Daily rounding by the night LN staff will be done to check for correct labeling and storage of drugs and biologicals along with the use of random audit checks by an RN for compliance. Central Supply	04NOV15	

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

PRINTED: 10/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135066	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/09/2015
NAME OF PROVIDER OR SUPPLIER POWER COUNTY NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 510 ROOSEVELT STREET (83211-1362) AMERICAN FALLS, ID 83211	
(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 431	<p>Continued From page 19</p> <p>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 properly stored and labeled in a room with two residents. This was true for 2 of 8 sampled residents (#2 and #6). The failed practices created the potential to cause harm for wandering or confused residents who may use the improperly stored medications. Findings included:</p> <p>On 10/05/15 at 4:00 pm, an unlabeled tube of Calmoseptine and Desitin ointments and a ¼ full bottle of Vashe wound therapy solution were found on the counter by the sink in the room shared by Resident #2 and #6. The back of the Vashe bottle said "Use this product within 30 days of opening."</p> <p>On 10/05/15 at 4:07 pm, the DON accompanied the two surveyors to the resident's room. When asked about the unlabeled tubes of medications and the wound therapy solution, the DON said the tubes of medications and wound solution should be labeled. The DON said the tubes of medications should be in the drawer and placed them inside the drawer. When asked about the Vashe solution when it was opened, DON said he did not know. When asked if the tubes of medication should be stored in the residents'</p>	F 431	<p>has also provided staff members with pocket Sharpies for easier labeling.</p> <p><u>Monitoring/Assurance:</u> As part of the RN's daily rounding assignments, a random room audit will be completed to check that creams and ointments are labeled and stored correctly. This audit will begin 11/2/2015 and be done twice a week for eight weeks, then once a week for four weeks, then once a month for three months. Any discrepancies will be reviewed at the monthly Quality Assurance Committee meeting.</p>	

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

PRINTED: 10/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135066	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/09/2015	
NAME OF PROVIDER OR SUPPLIER POWER COUNTY NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 510 ROOSEVELT STREET (83211-1362) AMERICAN FALLS, ID 83211		
(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 431 F 441 SS=D	Continued From page 20 room, the DON took the tubes from the drawer and removed all the aforementioned items from the room. 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (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. (c) Linens Personnel must handle, store, process and	F 431 F 441	F441 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS <u>Residents with potential to be affected:</u> All residents have the potential to be affected. <u>Corrective Actions:</u> Residents #2 and #6 share a common room and bathroom, the tubes of Calmoseptine they have were properly labeled for each resident and the used hand towel was removed at the time they were discovered. CNA #6 also received further instruction on infection control practices and proper use and care of linens. The staff received in-service training and handout at a 10/20/2015 meeting by the DON on preventing resident cross-contamination with medications and linens and a floor in-service review on 10/29/2015. <u>Measures to Prevent Recurrence:</u> Ongoing monthly infection control instruction and teaching will occur with each staff meeting presented by the DON, Infection Control Officer or designee. Random weekly audits will be completed by alternating LN staff to ensure labeling occurs with resident supplies and linen	04NOV15

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

PRINTED: 10/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135066	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/09/2015
NAME OF PROVIDER OR SUPPLIER POWER COUNTY NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 510 ROOSEVELT STREET (83211-1362) AMERICAN FALLS, ID 83211		
(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 441	<p>Continued From page 21</p> <p>transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, it was determined the facility failed to ensure infection control measures were implemented for 2 of 8 sampled residents (#2 and #6). The failure created the potential to cause infection from cross contamination when an unlabeled barrier cream was on the counter in a room with two residents and when a used cloth hand towel was left in 1 of 2 communal toilet rooms (across the hall from room 7). Findings included:</p> <p>1. On 10/05/15 at 4:00 pm, an unlabeled tube of Calmoseptine ointment was observed on the counter by the sink in a room shared by Resident #2 and #6.</p> <p>Resident #2's recapitulation (recap) of Physician Orders signed 9/15/15, included orders for Zinc Oxide 40% with ABD pad changes to the pannus every 6 hours and may use Calmoseptine (barrier cream) in between the ABD pad changes.</p> <p>Resident #6's recap of Physician Orders signed 9/15/15, included an order for Calmoseptine at bedside to be applied to the peri area as needed for incontinent episodes.</p> <p>The potential for cross contamination existed if the same tube of Calmoseptine was used for both residents.</p>	F 441	<p>checks to ensure they are handled appropriately and the environmental risks are minimized for possible resident cross-contamination.</p> <p><u>Monitoring/Assurance:</u> The Charge LN will monitor the work environment each shift with the supervising RN to ensure compliance by rounding, audit, and interview of staff. Additional instruction will be given to any staff in areas found to be non-compliant. The completion of the daily rounding tasks and weekly audit will be reviewed by the DON each week. This audit will begin 11/2/2015 and will continue twice a week for eight weeks, then once a week for four weeks, then once a month for three months. Any discrepancies will be reviewed at the Infection Control meeting.</p>		

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

PRINTED: 10/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135068	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/09/2015
NAME OF PROVIDER OR SUPPLIER POWER COUNTY NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 510 ROOSEVELT STREET (83211-1362) AMERICAN FALLS, ID 83211		
(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 441	Continued From page 22 ~ On 10/05/15 at 4:07 pm, the DON, accompanied two surveyors to the residents' room. When asked about the unlabeled tube of Calmoseptine on the counter, the DON said it should not be there and it should be labeled. 2. On 10/07/15 at 10:15 am, CNA #6 was observed assisting Resident #2 with toileting in the communal toilet room (across the hall from room 7). Resident #2 ambulated to the sink in the room, washed her hand then used an unfolded cloth hand towel that had been left on the shelf above the sink to dry her hands. After that, CNA #6 removed the used hand towel then assisted the resident to her room. On 10/07/15 at 10:25 am, CNA #6 was asked about the unfolded cloth hand towel that was left in the communal toilet. The CNA said the used towel should not have been left in the toilet room. She stated, "It is a no, no! Infection control right?"	F 441			
F 514 SS=E	483.75(I)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.	F 514	F514 483.75(I)(1) RES RECORDS COMPLETE/ACCURATE /ACCESSIBLE <u>Residents with potential to be affected:</u> All residents have the potential to be affected. <u>Corrective Actions:</u> The charts for Resident's #4, 5, 9, 12, 13, & 14 were reviewed by the MDS nurse on 10/19/2015. All recap orders were updated and now include the standing orders and insulin sliding scales as well.	04NOV15	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135066	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/09/2015
NAME OF PROVIDER OR SUPPLIER POWER COUNTY NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 510 ROOSEVELT STREET (83211-1362) AMERICAN FALLS, ID 83211		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	<p>Continued From page 23</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to maintain clinical records for each resident that were complete and accurate. This was true for 3 of 9 sampled residents (#s 4, 5 & 9) and 3 random residents (#s 12, 13, & 14) and created the potential for medical decisions to be based on incomplete or inaccurate information, which increased the risk for complications due to inappropriate care or interventions. Findings included:</p> <p>1. Resident #9 was admitted to the facility on 8/30/13 and readmitted on 5/27/15 with multiple diagnoses including Lewy bodies dementia and aspiration pneumonia.</p> <p>a) Resident # 9's medical record was reviewed on 10/6/15 and in her record was also laboratory results dated 4/17/15 for Resident #12 and Restorative Monthly Progress Notes dated from 11/1/13 through 4/14/15 for Resident #14.</p> <p>On 10/7/15 at 4:15 PM, the DON stated Resident #9's medical record contained other residents' records and he would immediately remove those documents and have them filed in the appropriate residents' records.</p> <p>b) The resident's Physician's Orders documented: *5/27/15 - Thick-IT with diagnosis of dysphagia/Diet: Diabetes Mellitus, Regular, Pureed, Honey Thick Liquids. *6/9/15 - Speech therapy evaluation/swallow evaluation.</p>	F 514	<p>Additional assistance from the medical records department reviewed and updated the tracking and storage of the long term care current resident and discharged/deceased files for completeness by 11/3/2015.</p> <p>The LN staff was also in-serviced on 10/20/2015 to complete timely and accurate documentation and to write any notes in the paper charts if they are unable to access the EMR.</p> <p><u>Measures to Prevent Recurrence:</u> The MDS nurse will update the Recap orders weekly with each new order received from copies sent by the LN staff. The MDS nurse will also review for accuracy, resident Recap orders at the monthly IDT, Stand-up and Pharmacy meetings. The RN will conduct a complete audit of two current resident charts a month for complete and accurate filing of progress notes, physician orders, consults, dietary changes, laboratory reports, etc. in the resident's chart along with a thinning of any overstuffed information. All older resident chart information will be sent to the medical records department for storage. The RN will also begin doing weekly chart audits starting 11/2/2015 for misfiled information, conduct chart thinning and perform quality checks for chart and order accuracy. The RN will review and place all discharged or deceased resident charting in a separate file for each resident. The file will</p>	

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

PRINTED: 10/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135066	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/09/2015
NAME OF PROVIDER OR SUPPLIER POWER COUNTY NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 510 ROOSEVELT STREET (83211-1362) AMERICAN FALLS, ID 83211		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 514	<p>Continued From page 24</p> <p>Resident #9's Speech Therapy/Swallowing Evaluation documented: *6/13/15 - Summary: No symptoms of dysphagia evidenced. Recommendations for diet: Mechanical soft, ground meats, and regular liquids.</p> <p>The resident's October 2015 recapitulation Physician's Orders documented: *Diet: 1500kcal Diabetic diet, mechanical soft, and regular liquids. *Thick IT for dysphagia</p> <p>On 10/8/15 at 10:35 AM, LN #7 stated Resident #9's recapitulation Physician's orders should have the "thick it for dysphagia" removed since the resident's liquids had been upgraded to a regular consistency.</p> <p>c) Resident #9's medical record documented the resident had aspirated a mandarin orange on 4/17/15 while eating lunch and went into respiratory distress. The day shift LN had documented in the resident's progress notes on 4/17/15 at 12:30 PM, 1:24 PM, 2:23 PM, 2:36 PM, 4:03 PM, 4:34 PM and 5:15 PM about the resident's condition and interventions. The night shift LN's assessments, which would have included the monitoring, interventions, and physician's involvement was not documented on 4/17/15. The resident was transported to the emergency room via ambulance in acute respiratory distress at 11:00 PM on 4/17/15. The LN documented the sequence of events on 4/23/15, 6 days after the episode had occurred. The resident's oxygen saturation was documented only twice on 4/17/15, with an oxygen saturation of 75% at 4:03 PM and 90% on</p>	F 514	<p>be sent to medical records and kept in a designated space for storage. The Health Information Manager and staff will audit resident file information received from the RN for completeness. They will maintain a separate and complete file for each long term care resident and store in a designated area in medical records.</p> <p><u>Monitoring/Assurance:</u> The DON will review the weekly chart audit completed by the RN for completeness and issues. This review will begin 11/2/2015 and will be done once a week for six weeks, then twice a month for two months, then monthly thereafter. Any discrepancies will be reviewed at the Quality Assurance Committee meeting.</p>		

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

PRINTED: 10/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135066	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/09/2015
NAME OF PROVIDER OR SUPPLIER POWER COUNTY NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 510 ROOSEVELT STREET (83211-1362) AMERICAN FALLS, ID 83211		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	<p>Continued From page 25 4 liters of oxygen at 4:34 PM.</p> <p>On 10/7/15 at 4:15 PM, the DON was interviewed about the resident's lack of documentation for the respiratory distress incident. The DON stated there was a lack of nursing documentation on 4/17/15 and related this to there being only one LN on duty, the need to care for all the other residents in addition to the care of Resident #9, who was monitored, suctioned, assessed, and finally transported to the hospital.</p> <p>2. Resident #13's October 2015 recapitulation Physician's Orders documented: *Lantus 42 units every nighttime for diabetes mellitus.-dated 5/26/15 *Fasting Blood Sugar before each meal and at bedtime- Sliding Scale Insulin Humilin R.-dated 6/21/13 150-199 1 unit 200-249 3 units 250-299 5 units 300-350 7 units 350-399 10 units 400-450 12 units</p> <p>The resident's record documented Physician's Orders and October 2015 MAR as follows: 8/17/15 - Change Lantus to 45 units daily in the evening. Change Sliding Scale Insulin to more aggressive scales. (See form in chart)</p> <p>Resident #13's Physician's Orders for Diabetes Management documented: 8/1/15 - Administer Lanuts 45 units subcutaneously daily at 9:00 PM. Administer Humilin R according to the Aggressive Sliding Scale: 150-199 2 units</p>	F 514		

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

PRINTED: 10/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135066	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/09/2015
NAME OF PROVIDER OR SUPPLIER POWER COUNTY NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 510 ROOSEVELT STREET (83211-1362) AMERICAN FALLS, ID 83211		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 514	<p>Continued From page 26</p> <p>200-249 4 units 250-299 7 units 300-349 10 units 250-399 12 units</p> <p>On 10/8/15 at 10:35 AM, LN #7 stated Resident #13's October 2015 recapitulation Physician's Orders had been updated to reflect the correct Lantus insulin dose and the aggressive sliding scale for the Humilin R insulin and was being held for the Physician's signature.</p> <p>3. Resident #12's October 2015 recapitulation Physician's Orders documented: *Insulin (Novolog) Sliding Scale for diabetes - dated 3/31/15. There was no documented sliding scale on the recaps.</p> <p>The resident's record documented Physician's Orders as follows: *3/18/15 - Fingerstick glucose before meals and at bedtime. Insulin Lispro with meals: 150-180 1 unit 180-210 2 units 210-240 3 units 240-270 4 units 270-300 5 units 300-330 6 units 330-360 7 units 360-390 8 units 390-420 9 units 420-450 10 units (The blood glucose readings overlapped.) *3/26/15 - Humalog not on patient's formulary, please find out what is on formulary and notify me. *3/31/15 - Novolog with same sliding scale as before. Discontinue Humalog Sliding Scale</p>	F 514			

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

PRINTED: 10/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135066	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/09/2015
NAME OF PROVIDER OR SUPPLIER POWER COUNTY NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 510 ROOSEVELT STREET (83211-1382) AMERICAN FALLS, ID 83211		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 514	Continued From page 27 Insulin. Resident #12's October 2015 MAR documented: *Novolog Solution 100 unit/ml Inject as per sliding scale: if 150 - 180 1 unit 181-210 2 units 211-240 3 units 241-270 4 units 271-300 5 units 301-330 6 units 331-360 7 units 361-390 8 units 391-420 9 units 421-450 10 units On 10/8/15 at 10:35 AM, LN #7 stated Resident #12's Novolog Sliding Scale needed to be documented on the current October 2015 recapitulation Physician's Orders. The LN stated the nurses administered the Novolog Insulin according to the current and correct MAR sliding scale documentation. 4. On 10/6/15 at 1:55 p.m., Resident #5's 7/16/15 recap of Physician Orders signed by the physician on 7/18/15 was found in Resident #4's clinical record. LN #1, who was in the Nurses' Station at the time, said the recap was in the wrong chart. The LN removed Resident #5's recap from Resident #4's chart.	F 514			
F 518 SS=E	483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using	F 518	F518 483.75(m)(2) TRAIN ALL STAFF- EMERGENCY PROCEDURES/DRILLS <u>Residents with potential to be affected:</u> All residents have the potential to be affected.	04NOV15	

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

PRINTED: 10/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135066	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/09/2015	
NAME OF PROVIDER OR SUPPLIER POWER COUNTY NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 510 ROOSEVELT STREET (83211-1362) AMERICAN FALLS, ID 83211		
(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 518	<p>Continued From page 28 those procedures.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and review of emergency preparedness plans and in-service records, it was determined the facility failed to ensure 2 of 3 staff (LN #3 and CNA #4) were trained to respond in emergency situations. The failure placed most of the residents at risk if the untrained staff were to respond inappropriately in any emergency situation. Findings included:</p> <p>On 10/7/15, the facility's emergency preparedness Emergency Quick Guides were reviewed. The guides included evacuation protocols, fire, missing resident, intruder(s), severe weather, including earthquakes, floods and power outage.</p> <p>a) On 10/7/15 at 4:30 p.m., LN #3, an agency nurse, was interviewed about emergency preparedness. The LN said this day was her fifth 12-hour shift working in the facility. Regarding a fire emergency, the LN said she did not know "which way they do it here" or where the pull alarms were. Regarding a power outage, the LN said she understood the facility had a generator but "I don't know what it does, or how extensive it is." She did not know where the "red outlets" were. (Red outlets are the only electrical outlets in the facility run by the generator during a power outage.) The LN did not know what to do after an earthquake. Regarding flooding, the LN said she had "never had training about that anywhere." Regarding an intruder, the LN said she did not know if the facility had a security person or not. The LN said she had been told where the</p>	F 518	<p><u>Corrective Actions:</u> Effective 10/27/2015, all new employee hires will be required to review and complete the online emergency response in-service and testing module with the Human Resources staff along with review of the facility's <i>Emergency Quick Guide</i> prior to working on the floor with residents. The facility's orientation checklist for agency nursing staff was also updated to include more time for agency staff to review the facility's <i>Emergency Quick Guide</i> and a walk-through of the facility with regular staff to review emergency exits, pull-alarms, fire extinguishers, and emergency outlets in case of an emergency or disaster prior to working on the floor with residents.</p> <p><u>Measures to Prevent Recurrence:</u> Agency and new staff must complete the required emergency prepare training prior to working the floor with residents and must sign and acknowledge that they have reviewed the materials and had the opportunity to ask questions.</p> <p><u>Monitoring/Assurance:</u> An RN will conduct a weekly emergency prepare question audit to randomly ask up to three staff on various shifts to test their knowledge of the facility emergency procedures. These checks will begin 11/2/2015 and</p>	

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

PRINTED: 10/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135066	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/09/2015
NAME OF PROVIDER OR SUPPLIER POWER COUNTY NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 510 ROOSEVELT STREET (83211-1382) AMERICAN FALLS, ID 83211	
(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 518	<p>Continued From page 29 emergency preparedness binder was and to read it, "but I haven't gotten to it."</p> <p>b) On 10/7/15 at 4:55 p.m., CNA #4, who had been employed just over a month, was interviewed about emergency preparedness. The CNA said she had not received any training about emergency preparedness but she had "glanced" through the emergency preparedness binder. The CNA said she did not know the facility's policies and procedures regarding evacuations, fire, missing resident, intruder, earthquake, floods or power outage. The CNA did not know the facility's code for a missing resident or earthquake. Regarding an intruder, the CNA said she would "stand my ground" and scream" for the nurse and co-workers.</p> <p>On 10/7/15 at 6:00 p.m., the Administrator was asked to provide documentation of emergency preparedness training for LN #3 and CNA #4.</p> <p>On 10/8/15 at 3:10 p.m., the Human Resources (HR) Director said CNA #3 had not started the facility's computer training regarding emergency preparedness. The HR Director said that LN #3 had signed paperwork regarding O.S.H.A. (Occupational Safety and Health Administration) training. The HR Director was asked to provide the documentation.</p> <p>On 10/8/15 at 4:00 p.m., the HR Director provided a document signed by LN #3 on 10/7/15 regarding "adherence to O.S.H.A. Blood borne Pathogens Exposure Control Plan, and Universal Precautions, District fire, disaster, hazardous material, MDS plan and safety plan, uses proper body mechanics." When reminded the LN said she had not read the facility's emergency</p>	F 518	<p>will be done once a week for two weeks, then twice a month for two months, and monthly for three months.</p> <p>Human Resources will also conduct checks of new employee and agency staff orientation files once a month to ensure completion of the training by new staff and report this to the Administrator. This review will begin the week of 11/2/2015 and will be done monthly for six months. Any discrepancies will be discussed at the monthly Quality Assurance Committee meeting.</p>	

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

PRINTED: 10/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135066	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/09/2015
NAME OF PROVIDER OR SUPPLIER POWER COUNTY NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 510 ROOSEVELT STREET (83211-1362) AMERICAN FALLS, ID 83211		
(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 518	Continued From page 30 preparedness plans, the HR Director said, "There is a disconnect."	F 518			

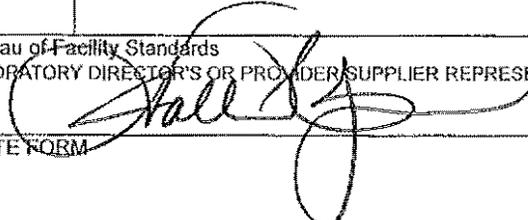
Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001630	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/09/2015
--	---	--	--

NAME OF PROVIDER OR SUPPLIER POWER COUNTY NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 510 ROOSEVELT STREET (83211-1362) AMERICAN FALLS, ID 83211
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	<p>16.03.02 INITIAL COMMENTS</p> <p>The following deficiencies were cited during the state relicensure survey conducted at the facility from October 5 to October 9, 2015.</p> <p>The surveyors conducting the survey were: Linda Hukill-Neil, RN, Team Coordinator Linda Kelly, RN Presie Billington, RN Angela Morgan, RN, BSN</p>	C 000		
C 412	<p>02.120.05,1 Cold Water Drinking Fountain Requirements</p> <p>I. A drinking fountain connected to cold running water and which is accessible to both wheelchair and nonwheelchair patients/residents shall be located in each nursing or staff unit.</p> <p>This Rule is not met as evidenced by: Based on observation, it was determined the facility did not have a drinking fountain connected to cold running water and accessible to both wheelchair and non-wheelchair residents located in each nursing or staff unit. Findings included:</p> <p>Throughout the week of survey, it was observed that there was not a water fountain connected to cold running water in the facility.</p> <p>On 10/9/15 at 4:00 p.m., the Administrator said he would reapply for a waiver for the drinking fountain.</p>	C 412	<p>C412 02.120,05,1</p> <p>Please see attached request for waiver for the requirement to have a water fountain available for residents on the ground floor of the nursing home.</p> <p style="text-align: right;">RECEIVED NOV - 6 2015 FACILITY STANDARDS</p>	04NOV15

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



TITLE

CEO / ADMINISTRATOR

(X6) DATE

04 Nov 2015



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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

November 16, 2015

Dallas Clinger, Administrator
Power County Nursing Home
PO Box 420
American Falls, ID 83211-0420

Provider #: 135066

Dear Mr. Clinger:

On **October 9, 2015**, an unannounced on-site complaint survey was conducted at Power County Nursing Home. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007007

The complaint was investigated in conjunction with the facility's on-site Recertification and State Licensure survey conducted from October 5 to October 9, 2015.

The following observations were completed:

Breakfast and 2 lunch observations;
Observation of resident and staff interactions from October 5 through October 9, 2015;
Observation of staff providing residents' daily care; and,
Medication pass and treatments were observed.

The following documents were reviewed:

Medical records of the identified resident were reviewed for Quality of Care concerns;
Medical records of five other residents were reviewed for Quality of Care concerns;
Resident Council minutes from May to October 2015;
Facility's Incident and Accident reports from May to October 2015; and,
Facility's Allegation of Abuse reports from May to October 2015.

The following interviews were completed:

Three residents and one family member were interviewed;
Seven residents in the Resident Group meeting were interviewed;

Director of Nursing Services, three nurses and five CNAs (Certified Nursing Aides) were interviewed; and,
The Administrator was interviewed for Quality of Care Concerns.

Allegation #1: The complainant stated an identified resident during lunch aspirated on some food sometime in April. The identified resident sounded like she was choking on food and the staff were not doing anything about it.

The complainant stated the identified resident had low oxygen saturation, "rattley" breathe sounds, and was slouched in a chair. The complainant stated the identified resident had a DNR (Do Not Resuscitate) code status, but the complainant did not understand why an ambulance was not called when the resident continued to have breathing difficulties. The complainant stated a nurse did not want to call 911, implying the facility would disapprove.

The complainant stated the ambulance was called later that evening and the identified resident was transported to the hospital. The resident was admitted to the hospital with acute medical concerns.

The identified resident's POA (Power of Attorney) wanted the resident readmitted to the facility after the hospitalization, but did not feel this would be an appropriate placement.

Findings #1: The identified resident had an aspiration incident during a lunchtime meal and was seen in the Emergency Room. The Emergency Room discharged the resident to the facility with orders to be monitored and interventions in place. The resident continued to experience respiratory distress signs and symptoms while nursing staff provided the ordered care. Later that same day, the resident was transported to the hospital on the authorized representative's wishes and against the advice of the physician. The resident was hospitalized, but has since returned to the facility.

Based on record review and staff interview, the allegation was substantiated and the facility was cited at F385 and F514. Refer to Federal Report 2567 for additional information.

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

Allegation #2: The complainant reported an identified resident stated facility staff were mean to her.

Findings #2: Observation of staff and resident interactions from October 5 to October 9, 2015 did not reveal any inappropriate behaviors from staff members;
Resident Council meeting minutes did not document any concerns with staff;
Residents in the group interview did not voice any concerns involving staff members;
Three residents and a family member did not express any concerns about staff members;
There were no grievances filed from January to October 9, 2015;
The facility's Incident and Accident reports did not document any inappropriate actions taken by staff members; and,

Dallas Clinger, Administrator
November 16, 2015
Page 3 of 3

The facility's Allegation of Abuse reports did not document any staff-to-resident abuse or neglect.

Based on observations, record review, and resident and family interviews, it was determined the allegation could not be substantiated due to a lack of evidence.

Conclusion #2: Unsubstantiated. Lack of sufficient evidence.

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

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

Sincerely,

DAVID SCOTT, RN, Supervisor
Long Term Care

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

DS/pmt