October 24, 2018

Lori Bentzler, Administrator  
Twin Falls Center  
674 Eastland Drive  
Twin Falls, ID  83301-6846  

Provider #: 135104

Dear Ms. Bentzler:

On **September 28, 2018**, a survey was conducted at Twin Falls Center by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be one that comprises a pattern that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567 listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct." **Please provide ONLY ONE completion date for each federal and state tag (if applicable) in column (X5) Completion Date** to signify when you allege that each tag will be back in compliance. **Waiver renewals may be requested on the Plan of Correction.**
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 5, 2018**. Failure to submit an acceptable PoC by **November 5, 2018**, may result in the imposition of penalties by **November 26, 2018**.

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 2, 2018 (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 **December 28, 2018**. A change in the seriousness of the deficiencies on **November 12, 2018**, may result in a change in the remedy.
The remedy, which will be recommended if substantial compliance has not been achieved by December 28, 2018 includes the following:

Denial of payment for new admissions effective December 28, 2018. [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 March 28, 2019, 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 Debby Ransom, RN, RHIT, Bureau Chief, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 5; 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 December 28, 2018 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:

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 5, 2018. If your request for informal dispute resolution is received after November 5, 2018, 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 Debby Ransom, RN, RHIT, Bureau Chief at (208) 334-6626, option 5.

Sincerely,

Debby Ransom, RN, RHIT, Chief
Bureau of Facility Standards

dr/lj
The following deficiencies were cited during an unannounced complaint investigation survey conducted at the facility from September 24, 2018 to September 28, 2018.

The surveyors conducting the survey were:

Linda Kelly, RN, Team Leader
Marcia Mital, RN

Abbreviations:

ADL = Activity(ies) of Daily Living
BM = Bowel movement (stool, feces)
BPH = Benign Prostatic Hyperplasia (enlarged prostate gland)
cm = centimeters
CNA = Certified Nursing Assistant
I&A = Incident and Accident
DNS = Director of Nursing Services
LPN = Licensed Practical Nurse
mg = milligrams
MDS = Minimum Data Set
PDS = Practice Development Specialist
PRN = As needed
RN = Registered Nurse
RRNM = Regional Resource Nurse Manager
SC = Staff Coordinator
SW = Social Worker
UM = Unit Manager

F 600

Free from Abuse and Neglect
SS=E
CFR(s): 483.12(a)(1)

§483.12 Freedom from Abuse, Neglect, and Exploitation
The resident has the right to be free from abuse, neglect, misappropriation of resident property,

10/31/2018
Electronically Signed
F 600 Continued From page 1

and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.

§483.12(a) The facility must-

§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;

This REQUIREMENT is not met as evidenced by:

Based on record review, facility policy review, review of investigations of allegations of abuse and neglect, and staff interview, it was determined the facility failed to ensure residents received the necessary care and services to prevent neglect. This was true for 5 of 12 residents reviewed (#8, #9, #10, #11, and #12). The failure created the potential for harm if residents experienced skin breakdown, infection, embarrassment, or humiliation from being left in wet and soiled incontinence products and bedding. Findings include:

The facility's Abuse Prohibition policy, revised 7/1/18, defined neglect as the failure to provide goods and services to a patient that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. This policy was not followed.

A Neglect Allegation Summary, undated, included an allegation of neglect by CNA #5 on 9/5/18. The summary stated 2 residents were found by a staff member soaking wet and 1 of the residents also had dried BM on her. The staff member

This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Twin Falls Center does not admit that the deficiency listed on this form exists, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency.

F600

Specific Residents Identified

On or before 11/9/18, an investigation of an allegation of neglect involving residents #8, #9, #11 and #12 will be completed by the Center Executive
Continued From page 2

stated it appeared they were not changed for several hours.

The investigation included resident and staff interviews, dated 9/7/18, which identified 5 residents (#8, #9, #10, #11, and #12) who did not receive incontinence care as needed.

The investigation included an undated written statement by UM #1 stating at 5:30 PM on 9/5/18, she asked CNA #5 if she needed help to get residents up, changed, or toileted. The statement documented CNA #5 replied she did not need help and everyone was up and were already changed.

A Witness Interview Record for CNA #2, dated 9/7/18, documented on 9/5/18 she saw "multiple" residents did not have their incontinence briefs changed and residents were complaining CNA #5 told them she did not have time to change them.

A Witness Interview Record for CNA #6, dated 9/7/18, documented on 9/5/18 between 5:00 and 5:30 PM, Resident #8's spouse asked CNA #5 to change Resident #8 and CNA #5 told him it would be after dinner. CNA #6 stated she assisted CNA #5 to change Resident #8 at approximately 7:30 PM, and Resident #8 was soaked through with urine and feces was coming out of her brief. CNA #6 also stated in the interview Resident #8's skin was irritated and red.

The conclusion of the investigation documented, neglect could not be substantiated due to insufficient information, although there was a statement from 1 staff member CNA #5 did not respond to a family member's request to change

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<td>stated it appeared they were not changed for several hours.</td>
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Director. Follow up will be completed including attempts to obtain missing statements from staff and any findings addressed. The allegation was reported to the state on 10/31/18 by the Center Executive Director.

Residents #8,9,11 and 12 will be reassessed by the Center Nurse Executive or designee for any adverse effects related to the allegation of neglect and for any needed changes to their plan of care including incontinence care. These assessments and any needed follow up or care plan updates will be completed by the Center Nurse Executive or designee on or before 11/9/18.

Resident #10 discharged on 9/11/18 from the facility.

Identification of Other Residents

Interviews of residents will be completed on or before 11/9/18 by Social Services staff or designee of all current interviewable residents in the facility regarding abuse or neglect including toileting and personal cares provided by staff to rule out additional allegations. Assessments of current non interviewable residents will be completed on or before 11/9/18 by the Center Nurse Executive or designee to rule out any additional allegations of abuse or neglect.
F 600 Continued From page 3

Resident #8. The investigation documented CNA #5 was terminated.

On 9/26/18 at 9:00 AM, CNA #2, said she was called to work the evening shift on 9/5/18. She arrived for work at 6:00 PM and began making rounds as soon as she arrived. The CNA said she found Resident #9, and her bed, soaked in urine and there was BM going down her leg. CNA #2 said Resident #9 was so wet and soiled, she and the SC gave her a shower that night and had to do a complete bed linen change.

On 9/26/18 at 12:58 PM, the SC said she helped CNA #2 give Resident #9 a bath and changed her bed linen sometime between 5:30 and 6:00 PM on 9/5/18. The SC said Resident #9's bed was soaked and soiled with BM. The SC said she was concerned Resident #9 was neglected because she was left laying in the soaked and soiled bed. The SC said she talked to CNA #5 around 8:00 PM on 9/5/18, and CNA #5 said she had not had a chance to go into Resident #9's room, but she received report Resident #9 was changed at 3:00 PM.

On 9/27/18 at 10:05 AM, the DNS stated her expectation was for staff to check and change residents incontinence briefs every 2 to 3 hours and to request help if needed.

Interviews will be completed on or before 11/9/18 by the Center Executive Director or designee of current staff members regarding abuse or neglect including toileting and personal cares provided by staff to rule out additional allegations.

Abuse/neglect investigations for the last 60 days of other residents in the facility will be reviewed by the Center Executive Director or designee on or before 11/9/18 to ensure that there are not any additional allegations noted that require additional investigation or follow up and that investigations are complete.

Systemic Changes

Center Executive Director and Center Nurse Executive will be educated by Regional Staff on or before 11/9/18 regarding the requirement of investigations related to abuse/neglect including investigation of all reported allegations by staff, investigations are reviewed to ensure that all components are completed and statements reviewed prior to the conclusion of the investigation.

Facility staff will be educated on or before 11/9/18 by the Center Executive Director or designee regarding the facility abuse/neglect policy including the requirement to immediately stop the abuse, report any allegations to the Center Executive Director and to
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<td>immediately remove the employee who is alleged to have committed the abuse. A post test will be completed to validate competency.</td>
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<td>Beginning 11/10/18, the Center Executive Director or designee will review new reportable investigations for completeness including ensuring that all allegations are investigated prior to the closure of the investigation.</td>
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<td>Beginning the week of 11/10/18, an audit of allegations of abuse or neglect will be reviewed by the Center Executive Director or designee to ensure that allegations were reported timely, that the resident was protected and that the investigation was thorough and complete. Beginning the week of 11/10/18, an interview of 5 residents related to any previously unidentified allegations of abuse or neglect will be completed to ensure that investigations and timely reporting is implemented.</td>
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<td>Audits will be completed weekly x 4 weeks and then monthly x 2 months. Reviews of each reportable investigation will be completed at the morning clinical meeting for 12 weeks by the facility interdisciplinary team to ensure completeness.</td>
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F 607  
SS=E  
Develop/Implement Abuse/Neglect Policies  
CFR(s): 483.12(b)(1)-(3)  

§483.12(b) The facility must develop and implement written policies and procedures that:  

§483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,  

§483.12(b)(2) Establish policies and procedures to investigate any such allegations, and  

§483.12(b)(3) Include training as required at paragraph §483.95,  

This REQUIREMENT is not met as evidenced by:  

Based on staff interview, review of clinical records, policies, and review of investigations of allegations of abuse and neglect, it was determined the facility failed to follow policies and procedures for investigating instances of potential neglect and abuse. This was true for 5 of 12 residents (#8, #9, #10, #11, and #12) who were identified in an investigation of potential neglect and abuse.

Results of the audits will be reported to the QAPI Committee monthly for 3 months for review and remedial intervention. The Center Executive Director is responsible for monitoring and compliance. The QAPI Committee will re-evaluate the need for further monitoring after 3 months.

Date of Compliance  
11/9/18  

Specific Residents Identified  
On or before 11/9/18, an investigation of an allegation of neglect involving residents #8, #9, #10, #11 and #12 will be...
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**NAME OF PROVIDER OR SUPPLIER**

**TWIN FALLS CENTER**

**STREET ADDRESS, CITY, STATE, ZIP CODE**

674 EASTLAND DRIVE
TWIN FALLS, ID 83301

**PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:**

135104

**MULTIPLE CONSTRUCTION**

**DATE SURVEY COMPLETED**

C 09/28/2018

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<th>ID PREFIX TAG</th>
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<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
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| F 607        | Continued From page 6 neglect, and had the potential to affect 34 other residents living in the 400 hall on 9/5/18. The failure created the potential for harm when suspected neglect was not immediately reported to the Administrator or designee, residents were not protected, an investigation of neglect for Residents #8 and #9 was not thorough, an allegation of neglect involving Residents #10 and Resident #11 was not investigated, and an allegation of rough care of residents was not investigated. Findings include: The facility's Abuse Prohibition policy, revised 7/1/18, included the following:  
* Anyone who witnesses an incident of suspected abuse or neglect is to tell the abuser to stop immediately and report the incident to his/her supervisor immediately.
* The notified supervisor will report the suspected abuse immediately to the Administrator or designee and other officials in accordance with state law.
* The employee alleged to have committed the act of abuse will be immediately removed from duty, pending investigation.
* Initiate an investigation within 24 hours of an allegation of abuse that focuses on whether abuse/neglect occurred and to what extent, clinical examination for signs of injuries, and if indicated, causative factors and interventions to prevent further injury.

The facility failed to initiate an investigation of suspected neglect on 9/5/18, within 24 hours. | F 607 completed by the Center Executive Director. Follow up will be completed including attempts to obtain missing statements from staff and any findings addressed. The allegation was reported to the state by the Center Executive Director on or before 11/1/18.

Residents #8,9,11 and 12 will be reassessed by the Center Nurse Executive or designee for any adverse effects related to the allegation of neglect and for any needed changes to their plan of care including incontinence care. These assessments and any needed follow up or care plan updates will be completed by the Center Nurse Executive or designee on or before 11/9/18.

On or before 11/9/18, an investigation of an allegation of rough care of residents will be completed by the Center Executive Director. Follow up will be completed as indicated. The allegation was reported to the State by the Center Executive Director on or before 11/1/18.

The Staffing Coordinator, CNA#2 and RN #1 will be educated on or before 11/9/18 regarding the facility abuse policy including the requirement to immediately stop the abuse and report any allegations to the Center Executive Director, and to immediately remove the employee who is alleged to have committed the abuse. |
A Neglect Allegation Summary, undated, included an allegation of neglect by CNA #5 on 9/5/18. The summary stated 2 residents were found by a staff member soaking wet and 1 of the residents also had dried BM on her. The staff member stated it appeared they were not changed for several hours.

The investigation included interviews, dated 9/7/18, which identified 5 residents (#8, #9, #10, #11, and #12) and documented multiple residents were not changed, and residents complained they were told by CNA #5 she did not have time to change them. One of the interviews on 9/7/18, also documented CNA #5 was “a little rough with the residents because she was angry.”

The Neglect Allegation Summary was incomplete. It did not include documented evidence the SC, who witnessed the neglect of Resident #9, or RN #1, who was aware of the suspected neglect for Resident #9 and Resident #10, were interviewed or gave a statement about the potential neglect on 9/5/18.

The investigation concluded neglect could not be substantiated due to insufficient information although the facility had a statement from 1 staff member CNA #5 did not respond to a family member’s request for Resident #8 to have her incontinence brief changed.

CNA #5 was terminated due to performance issues including not addressing Resident #8’s family request.

The facility’s policy related to suspected abuse

Resident #10 discharged on 9/11/18 from the facility.

Identification of Other Residents

Interviews of residents will be completed on or before 11/9/18 by Social Services staff or designee of all current interviewable residents in the facility regarding abuse or neglect including toileting and personal cares provided by staff or rough treatment to rule out additional allegations. Assessments of current non interviewable residents will be completed on or before 11/9/18 by the Center Nurse Executive or designee to rule out any additional allegations of abuse or neglect.

Interviews will be completed on or before 11/9/18 by the Center Executive Director or designee of current staff members regarding abuse or neglect including toileting and personal cares provided by staff or rough treatment to rule out additional allegations.

Abuse/neglect investigations for the last 60 days of other residents in the facility will be reviewed by the Center Executive Director or designee on or before 11/9/18 to ensure that there are not any additional allegations noted that require additional investigation or follow up and that investigations are complete.
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<td>F 607</td>
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<td>and neglect was not followed. Examples include:</td>
<td>F 607</td>
<td>Systemic Changes</td>
<td>Center Executive Director and Center Nurse Executive will be educated by Regional Staff on or before 11/9/18 regarding the requirement of investigations related to abuse/neglect including investigation of all reported allegations by staff, investigations are reviewed to ensure that all components are completed and statements reviewed prior to the conclusions of the investigations.</td>
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<td>1. On 9/5/18, suspected neglect was not immediately reported to administration after it was identified.</td>
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<td>On 9/26/18 at 9:00 AM, CNA #2 said she was called to work the evening shift on 9/05/18. She said she arrived for work at 6:00 PM, and made rounds as soon as she arrived. CNA #2 said she found Resident #9, and her bed, soaked in urine and she had BM down her leg. CNA #2 said Resident #9 was so wet and soiled she and the SC gave her a shower that night and had to do a complete bed linen change.</td>
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<td>On 9/26/18 at 9:00 AM, CNA #2 said she also found Resident #10 soaked with urine and her urinary catheter was leaking. CNA #2 said she cleaned and changed Resident #10 and also changed the bed linens. CNA #2 said she reported this to RN #1 that evening. CNA #2 said the DNS interviewed her a few days later.</td>
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<td>The SC said she talked to CNA #5 around 8:00 PM and CNA #5 said she had not had a chance to go into Resident #9's room, but she received report at 3:00 PM Resident #9 was changed. The SC said she did not report her concern about</td>
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neglect to the nurse that night, but she did report it to the RRNM the next morning.

On 9/26/18 at 11:35 PM, RN #1 said she was informed on the evening of 9/5/18, residents were left in urine and soiled clothing/bedding. RN #1 said the facility's policy was to immediately report concerns about abuse or neglect to the UM and the UM would immediately report to the DNS or Administrator. RN #1 said she did not report concerns of neglect on 9/5/18, to the UM, the DNS, or the Administrator.

2. CNA #5 was not immediately removed from duty when it was identified there was suspected neglect, per facility policy

On 9/26/18 at 12:58 PM, the SC said on 9/5/18 between 5:30 PM and 6:00 PM, she assisted CNA #2 to change and bathe Resident #9 who was soaked with urine and soiled with stool, and they also had to change her bed linens. The SC said she was concerned Resident #9 was neglected by CNA #5, and she talked to CNA #5 around 8:00 PM that night. The SC said she did not feel Resident #9 was in any danger after she was cleaned up and changed, and CNA #5 did work the rest of the shift which ended at 10:00 PM.

3. A Neglect Allegation Summary, undated, which occurred on 9/5/18, and involved Resident #8 and Resident #9, included 2 witness interview documents also identifying Resident #10, Resident #11, and Resident #12 as potential victims of neglect.

On 9/27/18 at 9:20 AM, the DNS said the
### Statement of Deficiencies and Plan of Correction

**Provider/Supplier/CLIA Identification Number:** 135104

**State:** ID

**Name of Provider or Supplier:** TWIN FALLS CENTER

**Address:** 674 EASTLAND DRIVE

**City:** TWIN FALLS

**State:** ID

**Zip Code:** 83301

**Date Survey Completed:** 09/28/2018

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| F 607 | Continued From page 10 residents, including Resident #10, Resident #11, and Resident #12, were interviewed, and they did not have any issues. The DNS said she did not review ADL records for Resident #10, Resident #11, and Resident #12, but "it would not be unusual to find a resident wet."

The facility did not provide any documented evidence the potential neglect on 9/5/18, of Resident #10, Resident #11, and Resident #12 was investigated.

4. A Witness Interview Record for CNA #6, dated 9/7/18, documented on 9/5/18, CNA #5 was "a little rough with the residents because she was angry."

On 9/27/18 at 9:20 AM, the DNS said CNA #6's interview statement that CNA #5 was rough with residents because she was angry, was subjective. The DNS said an allegation of neglect of 2 residents on 9/5/18, was already determined and CNA #5 was fired. The DNS said she did not investigate the allegation of rough care of residents because it was after the fact.

The facility did not conduct an investigation of the allegation of rough care of residents on 9/5/18. Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4)

§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:

§483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. | F 607 | 11/9/18 |

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**Department of Health and Human Services**

**Centers for Medicare & Medicaid Services**

**OMB No. 0938-0391**

**Printed:** 01/11/2019

**Form Approved:**

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**Event ID:** UM2F11

**Facility ID:** MDS001800

If continuation sheet Page 11 of 32
### STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

**NAME OF PROVIDER OR SUPPLIER:**
TWIN FALLS CENTER

**STREET ADDRESS, CITY, STATE, ZIP CODE:**
674 EASTLAND DRIVE TWIN FALLS, ID 83301

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARIZED STATEMENT OF DEFICIENCIES</th>
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<tr>
<td>F 610</td>
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§483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.

§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:

Based on staff interview, facility policy review, and review of investigations of allegations of abuse and neglect, it was determined the facility failed to ensure all allegations of abuse and neglect were thoroughly investigated. This was true for 5 of 12 residents reviewed (#8, #9, #10, #11, and #12). The failure created the potential for harm when suspected neglect of Resident #8 and Resident #9 was not thoroughly investigated, and potential neglect of Residents #10, #11, and #12 and potential "rough" care of all 5 residents was not investigated in order to rule out abuse or neglect. Findings include:

The facility's Abuse Prohibition policy, revised 7/1/18, stated an investigation would be initiated within 24 hours of an allegation of abuse. The policy stated the investigation focused on whether the abuse/neglect occurred, to what extent, and causative factors and interventions to prevent further injury. The policy also stated the facility was to provide a clinical examination for signs of injuries.

A Neglect Allegation Summary, undated, included:

F610

Specific Residents Identified

On or before 11/9/18, an investigation of an allegation of neglect involving residents #8, #9, #10, #11 and #12 will be completed by the Center Executive Director. Follow up will be completed including attempts to obtain missing statements from staff and any findings addressed. The allegation was reported to the State by the Center Executive Director on or before 11/1/18.

Residents #8, #9, #11 and #12 will be reassessed by the Center Nurse Executive or designee for any adverse effects related to the allegation of neglect and for any other needed changes to their plan of care including incontinence care. These assessments and any needed follow up or care plan updates will be completed by the Center Nurse Executive or designee on or before 11/9/18.
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<th>ID Prefix</th>
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<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
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<tr>
<td>F 610</td>
<td></td>
<td>Continued From page 12 an allegation of neglect by CNA #5 on 9/5/18. The summary stated 2 residents were found by a staff member soaking wet and 1 of the residents also had dried BM on her. The staff member stated it appeared they were not changed for several hours.</td>
<td>Continued From page 12 an allegation of neglect by CNA #5 on 9/5/18. The summary stated 2 residents were found by a staff member soaking wet and 1 of the residents also had dried BM on her. The staff member stated it appeared they were not changed for several hours.</td>
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<td>F 610</td>
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<td>On or before 11/9/18, an investigation of an allegation of rough care of residents will be completed by the Center Executive Director. Follow up will be completed as indicated. The allegation was reported to the State by the Center Executive Director on or before 11/1/18.</td>
<td>On or before 11/9/18, an investigation of an allegation of rough care of residents will be completed by the Center Executive Director. Follow up will be completed as indicated. The allegation was reported to the State by the Center Executive Director on or before 11/1/18.</td>
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On or before 11/9/18, an investigation of an allegation of neglect by CNA #5 on 9/5/18. The summary stated 2 residents were found by a staff member soaking wet and 1 of the residents also had dried BM on her. The staff member stated it appeared they were not changed for several hours.

The investigation included interviews, dated 9/7/18, which identified 5 residents (#8, #9, #10, #11, and #12) and documented multiple residents were not changed, and residents complained they were told by CNA #5 she did not have time to change them. One of the interviews on 9/7/18, also documented CNA #5 was "a little rough with the residents because she was angry."

The Neglect Allegation Summary was incomplete. It did not include documented evidence the SC, who witnessed the neglect of Resident #9, or RN #1, who was aware of the suspected neglect for Resident #9 and Resident #10, were interviewed or gave a statement about the potential neglect on 9/5/18.

On 9/26/18 at 9:00 AM, CNA #2, said she arrived for work at 6:00 PM on 9/5/18, and immediately began checking on residents. CNA #2 said she found Resident #9, and her bed, soaked in urine and feces down her leg. CNA #2 said she and the SC gave the resident a shower and had to do a complete bed linen change. CNA #2 said she also found Resident #10 soaked with urine and Resident #10's urinary catheter was leaking. The CNA said she cleaned and changed Resident #10 and also changed the bed linens. CNA #2 said she reported this to RN #1 that night.

On 9/26/18 at 12:58 PM, the SC said she helped

Identification of Other Residents

Interviews of residents will be completed on or before 11/9/18 by Social Services staff or designee of all current interviewable residents in the facility regarding abuse or neglect including toileting and personal cares provided by staff or rough treatment to rule out additional allegations. Assessments of current non interviewable residents will be completed on or before 11/9/18 by the Center Nurse Executive or designee to
TWIN FALLS CENTER

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<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
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<th>(X5) COMPLETION DATE</th>
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<td>CNA #2 give Resident #9 a bath and change her bed linens sometime between 5:30 and 6:00 PM on 9/5/18. The SC said Resident #9 was soaked with urine and soiled with stool.</td>
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<td>On 9/26/18 at 11:35 PM, RN #1 said she was informed on the evening of 9/5/18, residents were left in urine and soiled clothing/bedding. RN #1 said the facility's policy was to immediately report concerns about abuse or neglect to the UM, and the UM would immediately report to the DNS or the Administrator. RN #1 said she did not report concerns of neglect on 9/5/18 to the UM, the DNS, or the Administrator.</td>
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<td>On 9/27/18 at 9:20 AM, the DNS said the investigation of the allegation of neglect on 9/5/18, was started on 9/6/18, when she heard about it. The DNS said she was part of the investigation along with the Administrator and the SW. She said all of the residents, including Resident #10, Resident #11, and Resident #12, were assessed and found without problems. She stated the SW talked with the residents and they did not have any issues. The DNS said she did not review ADL records for Resident #10, Resident #11, and Resident #12, but &quot;it would not be unusual to find a resident wet.&quot; The DNS said the comment that CNA #5 was rough with residents, was subjective. The DNS said she did not ask the staff member what was meant by rough because CNA #5 was fired and it was after the fact.</td>
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<td>Documentation of the assessments for Resident #10, Resident #11, and Resident #12 were requested, however, none were provided.</td>
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<td>F 610 rule out any additional allegations of abuse or neglect.</td>
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<td>Interviews will be completed on or before 11/9/18 by the Center Executive Director or designee of current staff members regarding abuse or neglect including toileting and personal cares provided by staff or rough treatment to rule out additional allegations.</td>
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<td>Abuse/neglect investigations for the last 60 days of other residents in the facility will be reviewed by the Center Executive Director or designee on or before 11/9/18 to ensure that there are not any additional allegations noted that require additional investigation or follow up and that investigations are complete.</td>
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<td>Systemic Changes</td>
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<td>Center Executive Director and Center Nurse Executive will be educated by Regional Staff on or before 11/9/18 regarding the requirement of investigations related to abuse/neglect including investigation of all reported allegations by staff, investigations are reviewed to ensure that all components are completed and statements reviewed prior to the conclusions of the investigations.</td>
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<td>Facility staff will be educated on or before</td>
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| F 610 | Continued From page 14 | 11/9/18 by the Center Executive Director or designee regarding the facility abuse/neglect policy including the requirement to immediately stop the abuse, report any allegations to the Center Executive Director and to immediately remove the employee who is alleged to have committed the abuse. A post test will be completed to validate competency.

Beginning 11/10/18, the Center Executive Director or designee will review new reportable investigations for completeness including ensuring that all allegations are investigated prior to the closure of the investigation.

Monitoring

Beginning the week of 11/10/18, an audit of allegations of abuse or neglect will be reviewed by the Center Executive Director or designee to ensure that allegations were reported timely, that the resident was protected and that the investigation was thorough and complete. Beginning the week of 11/10/18, an interview of 5 residents related to any previously unidentified allegations of abuse or neglect will be completed to ensure that investigations and timely reporting is implemented.

Audits will be completed weekly x 4 weeks and then monthly x 2 months. Reviews of each reportable investigation will be completed at the morning clinical
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F 610 meeting for 12 weeks by the facility interdisciplinary team to ensure completeness.

Results of the audits will be reported to the QAPI Committee monthly for 3 months for review and remedial intervention. The Center Executive Director is responsible for monitoring and compliance. The QAPI Committee will re-evaluate the need for further monitoring after 3 months.

Date of Compliance
11/9/18

<table>
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<tr>
<th>F 684</th>
<th>Quality of Care</th>
<th>F 684</th>
<th>Specific Residents Identified</th>
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F 684 Specific Residents Identified

One or before 11/9/18, resident #2 will be assessed by the Center Nurse Executive or designee for adverse effects related to the protective boots not being in place as

§ 483.25 Quality of care

Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents’ choices. This REQUIREMENT is not met as evidenced by:

Based on observation, record review, and staff interview, it was determined the facility failed to provide care and ordered services for 2 of 12 residents (#2 and #3) who were reviewed. The failure increased the potential for Resident #2 to develop skin breakdown when her protective boots were not in place as ordered, and for Resident #3 to experience undetected
neurological changes when neurological assessments were not performed as ordered after unwitnessed falls. Finding include:

1. Resident #3 was admitted to the facility on 6/15/18, with multiple diagnoses including Alzheimer's disease and BPH with lower urinary tract symptoms. Hospice care was in place when he was admitted to the facility.

An admission MDS assessment, dated 6/22/18, documented Resident #3 had severely impaired cognition, he wandered on 1-3 days out of 7 days, which placed him at significant risk of getting to a potentially dangerous place, he needed extensive assistance from 1-2 people for all ADLs, he had limited range of motion in both lower extremities, and he had fallen prior to admission to the facility and had 1 fall with minor injury after admission to the facility.

Resident #3's care plan, dated 6/16/18, documented he had a history of falls and he was at risk for falls.

Resident #3's I&A reports included a Risk Management System Checklist. The Checklist documented neurological checks, or assessments, were to be done for all falls not witnessed by staff, and for head injuries. The checklist documented neurological checks were to be done every 30 minutes times 4, then every hour times 4, then every 4 hours times 6.

Resident #3's I&A reports documented his neurological status was not assessed or the assessments were incomplete when he had unwitnessed falls on 7/5/18, 7/26/18, 8/9/18, and ordered. Follow up will be completed as indicated including the care plan and Kardex being updated to reflect the resident's current status.

Resident #3 discharged from the facility on 10/22/18

Identification of Other Residents

On or before 11/9/18, the Center Nurse Executive or designee will review resident care plans and their Kardex for accuracy related to pressure injury prevention. Resident care plans and/or Kardex that have identified discrepancies will be revised to reflect the resident's current status and follow up completed by the nurse manager or designee to reflect resident current status and care and services provided. A bedside review will be completed on or before 11/9/18 by the Center Nurse Executive or designee of residents with orders for devices related to pressure injury prevention to ensure that they are in place.

On or before 11/9/18, a review of the falls that occurred within the last 30 days will be completed by the Center Nurse Executive or designee to ensure that neurological evaluations were completed as indicated. Follow up neurological evaluations will be completed by the Center Nurse Executive or designee on or before 11/9/18 with any additional follow
F 684 Continued From page 17
8/11/18. The I&A reports included the following:

* 7/5/18 at 2:00 PM - no neurological checks were completed.

* 7/26/18 at 9:30 PM - none of the 4 hour neurological checks were completed, for a total of 6 missing checks.

* 8/9/18 at 1:30 PM - no neurological checks were completed.

* 8/11/18 at 2:35 PM - the last 4 every 4 hour neurological checks were not completed.

On 8/28/18 at 1:32 PM, the PDS said she would look for documentation Resident #3’s neurological checks were done on 7/5/18, 7/26/18, 8/9/18, and 8/11/18. At 3:25 PM, the PDS said she did not find any other documentation the neurological checks were completed.

2. Resident #2 was readmitted to the facility on 9/11/18, with diagnoses which included dementia and reduced mobility.

Resident #2’s physician orders, documented a 9/20/18 order for Sage boots (a cushioned boot to protect the feet and heels from skin injury) to bilateral heels at all times when she was in her wheelchair.

A care plan, dated 5/11/18, and revised on 9/27/18, documented Resident #2 had skin breakdown and Sage boots were to be on when she was out of bed.

F 684 up completed as indicated by the review.

Systemic Changes

On or before 11/9/18, the Practice Development Specialist or designee will provide education to nursing staff regarding the center's policy for following the interventions listed on the care plan and Kardex. Education of the licensed nurses will be completed on or before 11/9/18 by the Practice Development Specialist or designee regarding the completion of all parts of the Risk Management System Checklist including neuro checks after a fall.

Beginning 11/10/18, a nurse manager or designee will review the comprehensive plan of care quarterly based on the MDS schedule to ensure that the care plan and Kardex are accurate regarding pressure injury prevention and review at the bedside that interventions are in place. Any identified discrepancies will be corrected at that time.

Monitoring

Beginning the week of 11/10/18 audits of 6 resident’s care plans and Kardex will be reviewed by the Center Nurse Executive or designee to ensure that the residents care plan has been updated to accurately reflect the residents current
### STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

<table>
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<tr>
<th>(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:</th>
<th>(X2) MULTIPLE CONSTRUCTION</th>
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<tbody>
<tr>
<td>135104</td>
<td>A. BUILDING ________________</td>
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<td>B. WING ________________</td>
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### DATE SURVEY COMPLETED

C 09/28/2018

### NAME OF PROVIDER OR SUPPLIER

TWIN FALLS CENTER

### STREET ADDRESS, CITY, STATE, ZIP CODE

674 EASTLAND DRIVE
TWIN FALLS, ID 83301

### SUMMARY STATEMENT OF DEFICIENCIES

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<tr>
<th>ID PREFIX</th>
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<td>(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</td>
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### F 684 Continued From page 18

A Skin Integrity Report, dated 9/20/18, documented Resident #2 had a blister on her left heel.

Resident #2 was observed on 9/25/18 at 8:12 AM, sitting up in her wheelchair. The Sage boots were not on her feet. The boots were on a table next to a TV in her room.

Resident #2 was observed on 9/25/18 at 10:24 AM, sitting in her wheelchair in her room without the boots on her feet.

On 9/27/18 at 11:20 AM, CNA #3 said she had not put the boots on Resident #2 when she got her up on 9/25/18. The CNA said she did not know Resident #2 was supposed to wear the boots because it was not on the Kardex (a document which listed cares and equipment for individual residents).

On 9/28/18 at 9:36 AM, the RRNM, stated the boots were not on Resident #2's Kardex on 9/25/18.

### F 686 Treatment/Svcs to Prevent/Heal Pressure Ulcer

CFR(s): 483.25(b)(1)(i)(ii)

§483.25(b) Skin Integrity
§483.25(b)(1) Pressure ulcers.
Based on the comprehensive assessment of a resident, the facility must ensure that-
- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and
- (ii) A resident with pressure ulcers receives necessary treatment and services, consistent status. Follow up for identified residents will be completed as indicated.

Beginning the week of 11/10/18, audits of each Risk Management System report will be completed by the Center Nurse Executive or designee to ensure accuracy and completion specifically completion of the Neuro checks as applicable.

Audits will be completed weekly X 4 then Monthly X 2. Results will be reported to the QAPI Committee meeting monthly for 3 months for review and remedial interventions. The Center Nurse Executive is responsible for monitoring and compliance. The QAPI Committee will re-evaluate the need for further monitoring after 3 months.

Date of Compliance
11/9/18
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| F686 | Continued From page 19 with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to implement a physician's order for a Registered Dietician's recommended supplement to aid in wound healing for 1 of 2 residents (Resident #2) who were reviewed for pressure ulcers. This had the potential to decrease and delay wound healing and increase the risk for infection and complications related to the wound. Findings include: Resident #2 was readmitted to the facility on 9/11/18, with diagnoses which included dementia and reduced mobility. A Skin Integrity Report, dated 9/11/18, documented Resident #2 had an unstageable wound to her left buttock which measured 2 cm by 1 cm. A Nutrition Progress Note, dated 9/18/18, stated Resident #2 required increased nutrition for wound healing and recommended a house supplement BID (twice a day) to promote wound healing through nutrition. Resident #2's record included a Physician's order summary report, dated 9/26/18, which did not include an order for the nutrition supplements recommended for wound healing. On 9/27/18 at 4:15 PM, the RRNM stated, the dietician's recommendation was sent to the
| F686 | Specific Residents Identified Resident #2's skin will be assessed on or before 11/9/18 by the Center Nurse Executive or designee, for any adverse effects from the failure to implement the dietician’s recommendation for a supplement to aid in wound healing and any findings addressed. Resident #2 will be reviewed on or before 11/9/18 by the Center Nurse Executive and the Center Registered Dietician for the continued need for a supplement. Any recommendations will be implemented. Identification of Other Residents On or before 11/9/18, current residents skin will be assessed by the Center Nurse Executive or designee to identify any previously unidentified skin impairments. A review of Dietician recommendations from the last 60 days will be completed on or before 11/9/18 by the Center Nurse Executive or designee to ensure that all recommendations were reviewed with the
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<td>physician and the physician signed it agreeing with the recommendation on 9/21/18. He stated someone had placed it in the chart, but had not written the order for the supplement.</td>
<td>physician and any orders that were obtained including physician notification, change in treatment, or care planned intervention will be completed by the Center Nurse Executive or designee on or before 11/9/18.</td>
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<td>Systemic Changes</td>
<td>Nursing Staff will be re-educated by the Practice Development Specialist or designee on or before 11/9/18 regarding the Genesis Skin Care Delivery process that includes but is not limited to pressure ulcer prevention measures including supplements and documentation requirements.</td>
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<td>Monitoring</td>
<td>Beginning the week of 11/10/18, an audit of 5 residents will be completed by the Center Nurse Executive or designee to ensure that there are no unidentified skin impairments, that recommendations/interventions including the dietician recommendations have been reviewed by the physician, any orders are in place, and that skin integrity care plans are in place. These audits will be completed weekly X 4 weeks and then monthly X 2 months. The results of these audits will be</td>
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Free of Accident Hazards/Supervision/Devices  F 689 11/9/18
SS=D 11/9/18

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<tr>
<td>F 689</td>
<td>Free of Accident Hazards/Supervision/Devices</td>
<td>CFR(s): 483.25(d)(1)(2)</td>
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<td>§483.25(d) Accidents.</td>
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<td>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and</td>
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<td>§483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents.</td>
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<td>This REQUIREMENT is not met as evidenced by:</td>
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<td>Based on record review, staff interview, facility policy review, and review of I&amp;A reports, it was determined the facility failed to ensure each resident received adequate supervision. This was true for 1 of 8 residents (Resident #3) who were reviewed for supervision. Failure to provide adequate supervision created the potential for harm if the resident had falls or accidents that resulted in injury or death. Findings include:</td>
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<td>Resident #3 was admitted to the facility on 6/15/18, with multiple diagnoses including Alzheimer's disease, and BPH with lower urinary tract symptoms. Hospice care was in place when</td>
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<td>reported to the QAPI Committee for review monthly for 3 months for review and remedial intervention. The Center Nurse Executive is responsible for monitoring and follow-up. The QAPI Committee will re-evaluate the need for further monitoring after 3 months.</td>
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Date of Compliance
11/9/18

Resident #3 discharged from the facility on 10/22/18.

Identification of Other Residents
On or before 11/9/18 an audit will be completed of current residents by the Center Nurse Executive or designee, to identify residents at risk for falls.
Residents at risk for falls will be reviewed at bedside to ensure that interventions are in place and that care plans/Kardex are updated to reflect the current resident status and follow up corrections completed as indicated.

On or before 11/9/18 residents will be reviewed for the level of supervision required by the Center Nurse Executive or designee. The Center Nurse Executive or designee will update the residents care plan and Kardex to reflect resident’s required level of supervision on or before 11/9/18.

Systemic Changes

On or before 11/9/18, the Practice Development Specialist or designee will provide education to Licensed Nursing Staff regarding resident fall risk, required supervision per resident care plan/Kardex, required documentation of supervision, implementation of preventative interventions and post fall assessments. Competency will be validated by a post test administered on or before 11/9/18 by the Practice Development Specialist or designee.

On or before 11/9/18, the Practice Development Specialist or designee will provide education to CNA staff related to reviewing the KARDDEX prior to starting shift assignment for care instructions including level of supervision, required
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| F 689 | continued from page 23 | | * Provide increased supervision with 15 minute checks, initiated on 7/22/18. On 8/23/18, the care plan was revised for 15 minute checks while he was in bed and one on one supervision while out of bed. The One on One Observation policy, revised 11/28/16, documented:  
* The person observing must be in the patient's room with complete view of the patient at all times or during times assessed as needing one on one observation.  
* Verification of constant observation/supervision at least every shift.
Resident #3 had 20 I&A reports between 6/17/18 and 9/24/18, related to falls. Resident #3 had falls documented on 6/18/18, 6/21/18, 7/4/18, 7/5/18, 7/20/18, 7/22/18, 7/26/18, 8/3/18, 8/6/18, 8/9/18, 8/11/18, 8/15/18, 8/17/18, 9/23/18, and 9/24/18. Resident #3 had 2 falls documented on 8/12/18 and 8/21/18. The I&A reports documented Resident #3 had skin tears as a result of falls on 6/18/18, 8/3/18, 8/12/18, and 8/21/18. Resident #3 had redness to his back from a fall on 8/11/18. Resident #3 had a bruise to his leg after a fall on 8/14/18. The facility did not implement 15 minute checks between 7/23/18, and Resident #3's fall on 8/21/18, as care planned on 7/22/18. After the second fall on 8/21/18, the 15 minute checks were inconsistent. In addition, there was no documentation in Resident #3's record one on one supervision, care planned on 8/21/18, was | F 689 | | documentation of supervision and fall prevention interventions.  
Beginning 11/10/18, CNA staff will review the KARDEX with the oncoming shift during the shift to shift report, the unit nurse will be responsible for monitoring compliance with this process.  
On or before 11/9/18, the Center Nurse Executive or designee will complete a center round to validate that care planned fall interventions are implemented at the bedside, required documentation of supervision is in place and follow up will be completed as indicated for any identified concerns.  
On or before 11/9/18, the Center Nurse Executive or designee will review residents with falls in daily clinical meeting for root cause and to ensure the care plan has been updated with appropriate interventions. Follow up will be completed as indicated.  
Beginning 11/10/18 residents who have a fall will be reviewed by the IDT in the weekly Customer at Risk meeting to evaluate effectiveness of interventions implemented post fall.  
Monitoring  
Beginning the week of 11/10/18, audits of |
### Statement of Deficiencies and Plan of Correction

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<th>Summary Statement of Deficiencies</th>
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<tr>
<td>F 689</td>
<td>Continued From page 24</td>
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<td>provided on 8/25/18 through 9/2/18 (9 days), 9/6/18, 9/7/18, 9/9/18, 9/10/18, 9/12/18, 9/16/18 through 9/19/18 (4 days), 9/21/18, or 9/23/18. On 9/26/18, the RRNM said daily staffing assignments included information about which staff member was assigned as the one on one. He said daily staffing assignments were not part of the resident's record, but one on one supervision should be documented in nursing notes. The RRNM also said the facility did not have a policy for 15 Minute Checks. On 9/28/18 at 1:51 PM, the PDS provided a stack of 15 Minute Check flowsheets and said she did not find 15 Minute Check flowsheets prior to 8/21/18.</td>
<td>11/9/18</td>
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<tr>
<td>F 758</td>
<td>Free from Unnec Psychotropic Meds/PRN Use</td>
<td>SS=D</td>
<td>CFR(s): 483.45(c)(3)(e)(1)-(5)</td>
<td>11/9/18</td>
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#### F 689

5 residents with falls will be completed by the Center Nurse Executive or designee, to ensure that resident fall risk has been reviewed and care plans have been updated to reflect the resident's current status with interventions implemented at the bedside as indicated. Any required documentation of increased supervision will also be reviewed to ensure that it is complete.

Audits will be completed weekly X 4 then Monthly X 2. Results will be reported to the QAPI Committee meeting monthly for 3 months for review and remedial interventions. The Center Nurse Executive is responsible for monitoring and follow-up. The QAPI Committee will re-evaluate the need for further monitoring after 3 months.

**Date of Compliance**

11/9/18
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<td>F 758</td>
<td>Continued From page 25</td>
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<td>Based on a comprehensive assessment of a resident, the facility must ensure that---</td>
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§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;

§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;

§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and

§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by:

Based on record review and family and staff
### Summary of Deficiencies

Resident #3 was admitted to the facility on 6/15/18, with multiple diagnoses including Alzheimer’s disease, dementia with behavioral disturbances, and adjustment disorder with depressed mood. Hospice care was in place when he was admitted to the facility.

An admission MDS assessment, dated 6/22/18, documented Resident #3’s had cognition which was severely impaired, he continuously had difficulty focusing his attention, which significantly interfered with his care and activities or social interaction, he wandered 1-3 days out of 7 days, and he was on an antipsychotic medication.

Resident #3’s current care plan, dated 6/16/18, included the following:

- He exhibited or was at risk for distressed/fluctuating mood symptoms related to depression and dementia with behavioral disturbances. Interventions included administration of antipsychotic and antidepressant medications as ordered and to monitor for signs and symptoms of worsening sadness and depression.
- He was at risk for complications related to the use of psychotropic medications. Interventions

#### Systemic Changes

On or before 11/9/18, the Practice Development Specialist or designee will provide education to licensed nursing staff regarding the requirement that consent must be obtained prior to the administration of an antipsychotic medication.

#### Monitoring

Beginning the week of 11/10/18, the Center Nurse Executive or designee will conduct a weekly audit of 5 residents with orders for antipsychotic medications to ensure that signed consents are completed. Any findings will be addressed on or before 11/9/18.
F 758  Continued From page 27
included completing behavior monitoring
flowsheets, gradual dose reductions as ordered,
and provide informed consent to the resident or
healthcare decision maker.

Resident #3's admission physician orders, dated
6/15/18, included:

* Lexapro 20 mg (antidepressant) 1 tablet by
mouth twice a day;

* Seroquel 50 mg (antipsychotic) by mouth every
morning and 200 mg by mouth every evening for
Alzheimer's with behavioral disturbances.

A Physician Progress Note, dated 6/26/18,
documented Resident #3 had a long-standing
history of Alzheimer's dementia and had
progressed to a nonverbal, nonambulatory, and
incontinent state. The physician reviewed the
medications with Resident #3's daughter who
lived out of state. The physician stated "He is on
supratherapeutic doses of antidepressants and
antipsychotic medications, but family has been
resistant to reducing these medications without
consulting his neurologist in Montana first."
Supratherapeutic doses are medications
administered at levels greater than would be
used in actual treatment of a medical condition.
The physician stated Resident #3's daughter also
insisted if he was asleep, he should be
awakened and given the medications. The
physician documented he had attempted to
contact the neurologist, but the neurologist was
not available.

On 6/29/18, Resident #3's neurologist decreased
the Seroquel to 25-50 mg at noon and 100 mg at

Audits will be completed weekly X 4 then
Monthly X 2. Results will be reported to
the QAPI Committee monthly for 3
months for review and remedial
interventions. The Center Nurse
Executive is responsible for monitoring
and compliance. The QAPI Committee
will re-evaluate the need for further
monitoring after 3 months.

Date of Compliance
11/9/18
### Statement of Deficiencies and Plan of Correction

**Name of Provider or Supplier:** TWIN FALLS CENTER  
**Street Address, City, State, Zip Code:** 674 EASTLAND DRIVE, TWIN FALLS, ID 83301

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<td>F 758</td>
<td>Continued From page 28</td>
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<td>A Progress Note by LPN #2, dated 6/30/18 at 3:18 PM, documented Resident #3 had behavioral symptoms of agitation and psychosis in the morning and this was reported to the hospice agency at 3:00 PM. LPN #2 documented Resident #3's daughter, who lived locally, was notified at 3:30 PM.</td>
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<td>A Progress Note by LPN #1, dated 6/30/18 at 3:51 PM documented, she reached out to the hospice agency to update them about Resident #3's worsening physical aggressive behavior. LPN #1 documented Hospice RN #1 had good rapport with Resident #3's daughter, and was reaching out to her to see if Ativan could be given to Resident #3. The progress note documented Hospice RN #1 will follow up with the floor nurse.</td>
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<td>A Progress Note by LPN #2, dated 6/30/18 at 3:57 PM, documented she reached out to the hospice agency to update them about Resident #3's worsening physical aggressive behavior. LPN #2 documented Hospice RN #1 had good rapport with Resident #3's daughter and was reaching out to her to see if PRN Ativan could be given to Resident #3. The progress note documented Hospice RN #1 will follow up with the floor nurse. This note was the same as LPN #1's entry 6 minutes earlier.</td>
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<td>A hospice progress note, dated 6/30/18, documented Hospice RN #1 received a report from an LPN at the facility Resident #3 had increased behaviors and he was not easily directed, and was combative with staff. Hospice</td>
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<td>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</td>
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<td>F 758</td>
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<td>RN #1 documented she notified the physician and received an order for Ativan 0.5 mg, 1 tablet by mouth every 6 hours as needed. Hospice RN #1 documented she notified facility staff of the new order and to administer the medication and call back in 1 hour if the Ativan was not effective. The note stated Hospice RN #1 called Resident's daughter who was the power of attorney, and she was agreeable to the medication. Resident #3's clinical record included a consent form for the Ativan, dated 6/30/18. LPN #1 and LPN #2 signed Resident #3's daughter, who lived locally, had given verbal consent for the Ativan. Resident #3's Medication Administration Record documented he was given the Ativan on 6/30/18 at 4:20 PM. A Progress Note by LPN #2, dated 7/1/18 at 7:18 AM, documented Resident #3 continued to be combative towards staff, was intrusive, and hard to redirect. A new order was received from the hospice agency for Haldol 2 mg three times a day. A Hospice order for Resident #3, dated 7/1/18, documented to start Haldol 2 mg 1 tablet PO [by mouth] three times daily for agitation/behaviors. A Progress Note by LPN #2, dated 7/1/18 at 3:18 PM documented, the first dose of Haldol was given at 12:00 PM. A Progress Note by the physician dated 7/2/18 documented, he was notified over the weekend Resident #3 was having increased agitation and physical aggression toward staff, was intrusively</td>
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wandering into other residents bedrooms and was unable to be redirected. The physician further documented, due to Resident #3's psychosis, Haldol was administered which was effective, but not sedating. He documented Resident 3's behaviors were markedly improved over the last 24 hours. The physician documented Resident #3 awakened easily in the morning and was able to form words and communicate more effectively than he had at previous encounters, and appeared to be much more effective than the high-dose Seroquel. The physician recommended no changes in the Haldol dose.

Resident #3's record included a consent form for the Haldol dated 7/1/18. LPN #1 and LPN #2 signed the form which documented Resident #3's daughter, who lived locally, had given verbal consent for the Haldol.

On 9/27/18 at 4:10 PM, LPN #1 reviewed both consents. LPN #1 said on 6/30/18, the Hospice nurse contacted Resident #3's daughter first and then she (LPN #1), contacted the local daughter and obtained verbal consent for the Ativan. LPN #1 stated she contacted Resident #3's local daughter and obtained verbal consent for the Haldol. LPN #1 said she contacted the local daughter because she was listed as Resident #3's first emergency contact.

On 9/28/18 at 9:55 AM, Resident #3's daughter who lived out of town, said the Hospice nurse called her on 6/30/18 about his behaviors and she consented to the Ativan. The daughter said she did not consent to Haldol on 7/1/18 and she did not learn about the Haldol until 2 days after it
### F 758 Continued From page 31

On 9/28/18 at 1:30 PM, Resident #3's daughter who lived locally, said she did not give consent for the Ativan or the Haldol and her sister was the one who authorized all of Resident #3's medications.

On 9/28/18 at 3:08 PM, LPN #2 said she talked with the hospice nurse on the morning of 7/1/18, because the Ativan was not helping, Haldol was suggested, and the hospice nurse said she would contact Resident #3's daughter who lived out of state and the physician. LPN #2 said the physician ordered the Haldol and she obtained verbal, not written, consent from Resident #3's daughter who lived locally when she was in the facility later that morning. LPN #2 said she did not get written consent even though the daughter was in the building.

On 9/28/18 at 3:12 PM, Hospice RN #1 said she knew the out-of-town daughter was Resident #3's power of attorney, and the daughter consented to the Ativan on 6/30/18 and to the Haldol on 7/1/18. Hospice RN #1 said she failed to document anything about the Haldol.

Neither of Resident #3's daughters consented to the use of Haldol.
April 5, 2019

Lori Bentzler, Administrator  
Twin Falls Center  
674 Eastland Drive  
Twin Falls, ID  83301-6846  

Provider #:  135104  

Dear Ms. Bentzler:  

On September 28, 2018, an unannounced on-site complaint survey was conducted at Twin Falls Center. The complaint was investigated during an unannounced complaint investigation survey conducted at the facility from September 24, 2018 to September 28, 2018. The complaint allegations, findings and conclusions are as follows:  

Complaint #ID00007677  

ALLEGATION:  

The facility did not check on or change residents through the night and left them in wet and soiled incontinence products.  

FINDINGS:  

The clinical records of 12 residents were reviewed. Grievance files, Incident and Accident (I&A) reports, Resident Council minutes, and investigations of allegations of Abuse/Neglect, for October 2017 through September 2018, were also reviewed. Interviews were conducted with ten residents, two family members, and multiple staff members, including nurses and Certified Nursing Assistants (CNAs), the Staff Coordinator (SC), and the Director of Nursing Services (DNS).
One resident's clinical record documented he frequently refused personal care and was often combative when staff attempted to assist him with toileting or provide incontinence care, even when they used care planned approaches for sweets and conversation about his dog. His record documented he frequently wandered about the facility in his wheelchair, refused to lay down at night, and preferred to stay up in his wheelchair.

A summary related to an investigation of an allegation of neglect in September 2018 documented a CNA found two residents whose incontinence briefs had not been changed for hours. The incontinence briefs for both residents were soaking wet, the bed linens for one of the residents were soaking wet, and dried feces was found on one of the residents. The investigation itself included staff interviews in which 5 residents in total were identified as not receiving incontinence care as needed. The clinical records of those five residents documented all of them needed the staff to provide incontinence care.

One CNA said shortly after she arrived for work one evening she found a resident who was so wet and soiled she needed a shower and a complete bed change. The SC said she helped the CNA give the resident a shower and change the bed linens. The DNS said she expected the staff to check and change residents' incontinence briefs every 2 to 3 hours, and more often when needed.

Based on the investigative findings, incontinence care was not consistently provided in a timely manner and some residents were left in wet and soiled incontinence products and/or bedding. The allegation was substantiated and the facility was cited for deficient practice.

CONCLUSIONS:

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

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

If you have any questions, comments or concerns regarding this matter, please contact Laura Thompson, RN, or Belinda Day, RN, Supervisors, Long Term Care Program at (208) 334-6626, Option #2.

Sincerely,

Laura Thompson, RN, Supervisor
Long Term Care Program
April 10, 2019

Lori Bentzler, Administrator
Twin Falls Center
674 Eastland Drive
Twin Falls, ID  83301-6846

Provider #: 135104

Dear Ms. Bentzler:

On September 24, 2018 through September 28, 2018, an unannounced on-site complaint survey was conducted at Twin Falls Center. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007782

ALLEGATION #1:

The facility failed to provide appropriate incontinence care and appropriately maintain a CPAP device.

FINDINGS #1:

Interviews were conducted with 10 residents, two family members, and multiple staff members and 12 resident records were reviewed. Observations were conducted throughout the facility, including observations on the night shift. Facility grievances were reviewed.

One resident's record, who used a CPAP machine, was reviewed and there was no documentation of a broken CPAP in the resident's record or observed in the facility. Two other residents with CPAP machines were reviewed without evidence of deficient practice.
Observations on the night shift and resident/staff interviews did not identify concerns with staffing or incontinence care, particularly on the night shift.

Although the allegations were substantiated, the facility was not cited with deficient practice because the investigation did not substantiate current deficient practice.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The facility failed to ensure a PICC line was properly maintained to prevent infection.

FINDINGS #2:

During the investigation interviews were conducted with 10 residents, two family members, and multiple staff members. Observations were conducted throughout the facility, including observations on the night shift. There were 12 resident records reviewed.

A facility investigation was reviewed for one resident which stated the dressing and needleless connectors were not changed as ordered by the physician. The facility in-serviced and completed competencies for all nursing staff on Peripherally Inserted Central Catheter (PICC) lines and intravenous (IV) lines. The facility completed audits of all residents with PICC lines. Licensed nursing staff were interviewed about PICC line care and the staff answered appropriately. There were no current residents in the facility with IV or PICC lines during the survey.

The allegation was substantiated but the facility was not cited with deficient practice because no current deficient practice was identified.

CONCLUSIONS:

Substantiated. No deficiencies related to the allegation are cited.

ALLEGATION #3:

The facility failed to keep a clean environment.

FINDINGS #3:

During the investigation interviews were conducted with 10 residents, two family members, and
multiple staff members. Observations were conducted throughout the facility, including observations on the night shift. There were 12 resident records reviewed.

A facility grievance was reviewed which stated a dirty bedpan was left in a residents' room. A CNA had forgotten to empty the bedpan and dispose of the dirty brief after providing care to the resident. Observations during the survey revealed the environment was clean and no dirty bedpans were observed. There were 12 residents reviewed for cares without concerns.

The allegation was substantiated, but the facility was not cited with deficient practice because there was no current deficient practice.

CONCLUSIONS:

Substantiated. No deficiencies related to the allegation are cited.

ALLEGATION #4:

The facility failed to ensure resident's family members were informed for significant changes in the resident's condition.

FINDINGS #4:

During the investigation interviews were conducted with 10 residents, two family members, and multiple staff members. Observations were conducted throughout the facility, including observations on the night shift. There were 12 resident records reviewed.

A facility investigation of one resident stated they had experienced a fractured ankle. The resident was interviewed as part of the investigation and stated she had pain in her ankle for about 3 weeks, but just reported a few days ago and asked for the physician to look at it. The resident stated she was working with therapy about 3 weeks ago when she ran into another wheelchair pedal while in her electric wheelchair. The resident reported she did not recall having any pain to her left foot/ankle at that time. She stated she had been careful to not hit anything since then and did not recall how long after that the pain in her ankle started. The resident reported she had not had any accidents/falls. She stated she was unsure what could have caused the fracture. The resident denied any abuse from staff or others in the facility.

The resident's Medication Administration Record for November 2017 did not include documentation the resident complained of pain to her ankle until 11/08/17, and she was seen by the physician on 11/09/17. The physician ordered an x-ray which was done on 11/09/17, which identified an ankle fracture.
The resident's record did not include documentation of any complaints of pain to her ankle prior to when it was identified. The assessment documented there was no bruising to the ankle/foot.

The physician's progress note documented "Left ankle pain . . . She has reported pain and swelling in the left ankle . . . the pain started on 11/8/17. She describes it as a stiff ankle with a throbbing sensation . . . There is some swelling but no bruising or obvious deformity of the left ankle. She is able to actively flex and extend ankle, but verbalizes pain when doing so." A subsequent physician progress note documented "what is certain is that she has osteoporosis . . . this places her at high risk for pathological fractures . . . it is probably osteoporotic related and unavoidable."

A written statement by the Physical Therapist (PT), stated the resident only worked with the PT one time the previous month, and the therapist had not observed the resident bump her foot or hit anything during therapy.

A written statement by the Certified Occupational Therapy Assistant (COTA), documented the resident worked with occupational therapy three times and the resident was not observed to bump or hit her foot/ankle on anything during her therapy.

Based on investigative findings the allegation was not substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

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

If you have any questions, comments or concerns regarding this matter, please contact Laura Thompson, RN, or Belinda Day, RN, Supervisors, Long Term Care Program at (208) 334-6626, Option #2.

Sincerely,

Laura Thompson, RN, Supervisor
Long Term Care Program