April 19, 2019

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

Provider #:  135104

Dear Ms. Bentzler:

On April 1, 2019, 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 in your facility to be ISOLATED and to constitute immediate jeopardy to residents' health and safety. You were informed of the immediate jeopardy situation(s) in writing on March 29, 2019.

On March 29, 2019, the facility submitted a credible allegation that the immediate jeopardy was corrected. After review of your Plan of Correction, it was determined that the immediate jeopardy to the residents had been removed. However, the deficiencies as identified on the revised Form CMS-2567 remain and require a Plan of Correction. The most serious deficiency now constitutes actual harm that is not immediate jeopardy and that is isolated in scope, as evidenced by the Form CMS-2567, whereby significant corrections are required.

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567 listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. NOTE: The alleged compliance date must be after the "Date Survey Completed" (located in field X3.) Please provide ONLY ONE completion date for each federal and state tag (if applicable) in column (X5) Completion Date to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.
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 **April 29, 2019**. Failure to submit an acceptable PoC by **April 29, 2019**, may result in the imposition of additional civil monetary penalties by **May 22, 2019**.

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.
- 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*.

Based on the immediate jeopardy cited during this survey:

**F0678 -- S/S: J -- 483.24(a)(3) -- Cardio-Pulmonary Resuscitation (cpr)**

This agency is required to notify Centers for Medicare & Medicaid Services (CMS) Regional Office of the results of this survey.
We are recommending to the CMS Regional Office that the following remedies be imposed:

- Civil money penalty
- Denial of Payment for New Admission effective July 1, 2019

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **October 1, 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 and Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

Your facility's noncompliance with the following:

- **F0678 -- S/S: J -- 483.24(a)(3) -- Cardio-Pulmonary Resuscitation (cpr)**

has been determined to constitute substandard quality of care (SQC) as defined at 42 CFR §488.301. Sections 1819 (g)(5)(c) and 1919 (g)(5)(c) of the Social Security Act and 42 CFR §488.325 (h) requires the attending physician of each resident who was found to have received substandard quality of care, as well as the state board responsible for licensing the facility's administrator be notified of the substandard quality of care. In order for us to satisfy these notification requirements, and in accordance with 42 CFR §488.325(g), you are required to provide the following information to this agency within ten (10) working days of your receipt of this letter:

The name and address of the attending physician of each resident found to have received substandard quality of care, as identified below:

Resident #53 as identified on the enclosed Resident Identifier List.

Please note that in accordance with 42 CFR §488.325(g), your failure to provide this information timely will result in termination of participation or imposition of additional remedies. If you believe the deficiencies have been corrected, you may contact Belinda Day, RN, or Laura Thompson, RN, Supervisors LTC, 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.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You may also contest scope and severity assessments for deficiencies, which resulted in a finding of SQC or immediate jeopardy. 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 **April 29, 2019**. If your request for informal dispute resolution is received after **April 29, 2019**, 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 Belinda Day, RN or Laura Thompson, RN, at (208) 334-6626, option 2.

Sincerely,

Belinda Day, RN
Chief
Bureau of Facility Standards

BD/lj

c: Chairman, Board of Examiners - Nursing Home Administrators
The following deficiencies were cited during the federal recertification and complaint survey conducted on March 25, 2019 to April 1, 2019.

Immediate jeopardy to residents' health and safety was cited at F678. The jeopardy was removed prior to the exit conference.

The surveyors conducting the survey were:

- Jenny Walker, RN, Team Coordinator
- Wendi Gonzales, RN
- Roxie Lacey, RN

Acronyms used in the report include:

- ADL = Activities of Daily Living
- CCM = Care Case Manager
- cm = centimeter
- CNA = Certified Nursing Assistant
- CHF = Congestive Heart Failure
- CNE = Center Nurse Executive
- CPR = Cardiopulmonary Resuscitation
- DON = Director of Nursing
- DNR = Do Not Resuscitate
- HCL = Hydrochloric
- I&A = Incident & Accident
- ICN = Infection Control Nurse
- IDT = Interdisciplinary Team
- LPN = Licensed Practical Nurse
- LSW = Licensed Social Worker
- MAR = Medication Administration Record
- mcg/hr = micrograms per hour
- MDS = Minimum Data Set
- mg = milligrams
- MOLST = Medical Orders for Life-Sustaining
## Statement of Deficiencies and Plan of Correction

**Name of Provider or Supplier:** TWIN FALLS CENTER  
**Address:** 674 EASTLAND DRIVE, TWIN FALLS, ID 83301

### Summary Statement of Deficiencies

**ID Prefix TAG** | **Summary Statement of Deficiencies** |
--- | ---|
F 000 | Continued From page 1 Treatment
POST = Physician Orders for Scope of Treatment  
PRN = as needed  
Resuscitate = Full Code  
RN = Registered Nurse  
RNA = Restorative Nursing Assistant  
RSD = Resident Services Director  
TAR = Treatment Administration Record  
WCN = Wound Care Nurse

**ID Prefix TAG** | **Provider's Plan of Correction** |
--- | ---|
F 000 | F 000

**ID Prefix TAG** | **Completion Date** |
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F 552 | 5/21/19

**ID Prefix TAG** | **Completion Date** |
--- | ---|
F 552 | 5/21/19

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**F 552**  
**SS=D**  
**Right to be Informed/Made Treatment Decisions**  
**CFR(s): 483.10(c)(1)(4)(5)**  
§483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including:

§483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition.

§483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care.

§483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is not met as evidenced by:

Based on record review, policy review, and staff interview, it was determined the facility failed ensure residents receiving psychotropic medication had consents in place prior to initiation of the medications. This was true for 2

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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
### F 552 Continued From page 2

of 5 residents (#32 and #35) reviewed for unnecessary medications. This deficient practice placed residents at risk of receiving psychotropic medications without knowledge of the risks and benefits associated with each medication, alternative treatment options, and the right to refuse the medications. Findings include:

The facility's Psychotropic Medication Administration policy, dated 8/15/17, directed staff to obtain psychotropic medication informed consents.

1. Resident #32 was admitted to the facility on 2/16/19, with multiple diagnoses including bipolar disorder, schizophrenia, and anxiety disorder.

Resident #32's physician's orders, dated 3/14/19, documented an order for Latuda 20 mg (an antipsychotic used to treat schizophrenia).

Resident #32's March 2019 MAR documented she received the Latuda from 3/15/19 to 3/29/19.

Resident #32's record did not contain a consent for the Latuda.

On 3/29/19 at 3:05 PM, LPN #2 said she thought she had obtained a consent for the Latuda but could not find it in Resident #32's record.

On 3/28/19 at 3:15 PM, the DON said she expected staff to obtain a consent for Resident #32's psychotropic medications.

2. Resident #35 was admitted to the facility on 2/16/19, with multiple diagnoses including dementia, anxiety, and Alzheimer's disease.

Resident #35 began hospice care on 3/12/19.

### F 552

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.

F552

Specific Residents Identified

Resident #32 was discharged on 04/11/19.

Resident #35 was reviewed by the physician on 4/2/19 and the Lorazepam was discontinued.

Identification of other residents

A review of other residents will be completed by the Center Nurse Executive or designee on or before 5/21/19 to validate consents are in place. Consents and education of the risks and benefits will be provided to the residents and/or representatives at the time of review as indicated by the Center Nurse Executive or designee on or before 5/21/19.

Systemic Change

The interdisciplinary team and licensed
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<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
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<td>compliance. The QAPI Committee will re-evaluate the need for further monitoring after 3 months.</td>
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<td>Request/Refuse/Dsctnue Trmnt;Formlte Adv Dir</td>
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<td>SS=D</td>
<td>CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v)</td>
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§483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.

§483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.

§483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).

(i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.

(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.

(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.

(iv) If an adult individual is incapacitated at the time of admission and is unable to receive...
F 578 Continued From page 5

information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law.

(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.

This REQUIREMENT is not met as evidenced by:

Based on policy review, record review, and family and staff interview, it was determined the facility failed to ensure a copy of a resident's living will was requested and present in his record and his resuscitation code status clarified. This was true for 1 of 14 residents (Resident #53) reviewed for advance directives. This failure created the potential for harm if a resident's medical treatment wishes were not followed due to lack of information in his clinical record.

Findings include:

The facility's Health Care Decision Making policy, dated 1/1/13, directed staff to support the right of residents to prepare an advance directive declaration or statement which clearly expressed the patient's wishes regarding the use of the life prolonging procedures and/or designating another person to make treatment decisions in the event that the resident becomes incapable of communicating his or her choices or wishes.

Resident #53 was admitted to the facility on 2/27/19, with multiple diagnoses including congestive heart failure, falls with closed head

F 578

Specific Residents Identified

Resident #53 was discharged on 3/17/19

Identification of Other Residents

The Director of Social Services or designee reviewed medical records of current residents for advanced directives on or before 5/21/19. Residents identified as not having advanced directives were provided education on living wills. If an advanced directive was not able to be obtained the Director of Social Services or designee noted the contact with the resident or responsible party in the medical record and updated the care plan with any changes on or before 5/21/19. The Director of Social Services or designee reviewed the current code status with the resident or responsible
### Summary Statement of Deficiencies

Each deficiency must be preceded by full regulatory or LSC identifying information.

**F 578** Continued From page 6

- Injury, and current use of anticoagulant medication (blood thinner).

- Resident #53’s Initial Nursing Assessment, dated 2/27/19, documented he was alert and oriented to person, place, and time. The assessment also documented Resident #53’s judgement and insight was intact.

- Resident #53’s POST form, located in his record, documented Resuscitate (Full Code) with aggressive interventions, and he had a living will. Resident #53 signed the POST form on 2/27/19, and the physician signed it on 2/28/19.

- A Care Plan Meeting Note, dated 3/14/19 at 12:22 PM, signed by the LSW, documented Resident #53 signed the POST form on 2/27/19, and the physician signed it on 2/28/19.

- On 3/28/19 at 5:47 PM, Resident #53’s son stated Resident #53 had a living will and his code status was DNR (Do Not Resuscitate). Resident #53’s son stated he did not provide the living will to the facility and was unaware Resident #53’s POST form documented his code status was Full Code with aggressive interventions.

- On 3/28/19 at 6:58 PM, the LSW stated she was party and ensured a copy of the POST form and advanced directive was placed in the resident’s medical record on or before 5/21/19.

### Systemic Changes

- The interdisciplinary team and licensed nurse staff will be educated by the Center Nurse Executive or designee on obtaining, reviewing advanced directives and documenting discussions regarding advanced directives on or before 05/21/19.

- Beginning 5/6/19, during the post admission care conference and quarterly care plan conferences residents and/or their representatives will be given the opportunity by the social services staff or designee to review a current or complete an new advanced directive. Any changes will be updated on the POST form, care plan and physician order obtained.

- Monitoring

- Beginning the week of 5/22/19 the Center Nurse Executive or designee will review 5 current resident records for advanced directives. These audits will be completed weekly times 4 weeks and monthly times 2 months. The Center Nurse Executive or designee will compile the results of the audits and report to the QAPI committee.
### Statement of Deficiencies and Plan of Correction

**Provider/Supplier/CLIA Identification Number:** 135104  
**State:** 674 EASTLAND DRIVE  
**City, State, Zip Code:** TWIN FALLS, ID 83301  
**Date Survey Completed:** 04/01/2019

**Summary Statement of Deficiencies**

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<th>Summary Statement of Deficiencies</th>
<th>Provider's Plan of Correction</th>
<th>Completion Date</th>
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unaware Resident #53’s POST form documented his code status as Full Code and he marked that he had a living will. The LSW stated a copy of Resident #53’s living will was not in his record.  
The facility failed to ensure a copy of Resident #53’s living will was requested and his resuscitation code status clarified. | monthly times 3 months for review and remedial intervention. 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  
5/21/19 |
| F 600 | SS=G | | Free from Abuse and Neglect  
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, 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 staff interview and record review, it was determined the facility failed to ensure 1 of 1 resident (Resident #53) reviewed for death in the facility was provided CPR per his wishes documented on his POST form. The licensed staff neglected to verify Resident #53’s code status when he did not have an apical pulse (heart beat) or respirations and neglected to | F600  
Specific Residents Identified  
Resident #53 discharged on 3/17/19 from the facility. | 5/21/19 |
F 600  Continued From page 8

initiate CPR per his documented wishes. The failure may have contributed to Resident #53’s death and placed the other 22 residents residing in the facility with a code status of Full Code (initiate resuscitation) at risk of not receiving CPR per their wishes. Findings include:

Resident #53 was admitted to the facility on 2/27/19, with multiple diagnoses including congestive heart failure (CHF), falls with closed head injury, and current use of anticoagulant medication (blood thinner).

Resident #53’s hospital Admission History and Physical, dated 2/24/19 at 3:42 AM, documented he his code status was Full Code and was electronically signed by a Nurse Practitioner.

Resident #53’s Initial Nursing Assessment, dated 2/27/19, documented he was alert and oriented to person, place, and time. The assessment also documented Resident #53’s judgement and insight was intact.

Resident #53’s POST form, located in his record, documented Resuscitate (Full Code) with aggressive interventions for cardiopulmonary resuscitation in the event he did not have a pulse and/or was not breathing. The aggressive interventions included intubation, mechanical ventilation, and that the receiving hospital may admit him to intensive care. Resident #53 signed the POST form on 2/27/19, and the physician signed it on 2/28/19.

Resident #53’s March 2019 Physician Orders did not include his code status.

F 600  Identification of Other Residents

Interviews of residents will be completed on or before 5/21/19 by the Director of Social Services or designee of current interviewable residents in the facility regarding any concerns of abuse or neglect. Any concerns of abuse or neglect will be reported and investigated immediately.

A review of their POST/code status will be completed with current interviewable residents on or before 5/21/19 by the Director of Social Services or designee. Any changes in code status will be updated on the POST form, care plan and physician orders obtained.

The POA designees or resident representatives of non interviewable residents will be interviewed on or before 5/21/19 by the Director of Social Services or designee regarding any concerns of abuse/neglect. Any concerns of abuse or neglect will be reported and investigated immediately. A review of their POST/code status will be completed with the POA/resident representatives of non interviewable residents on or before 5/21/19 by social services staff or designee. Any changes in code status will be updated on the care plan, POST and physician orders obtained.

Abuse/neglect investigations and deaths that occurred in the facility for the last 45
F 600 Continued From page 9

Resident #53's care plan, dated 3/8/19, documented his code status was "Full Code."

A Nurse's Progress Note, dated 3/17/19 at 10:34 AM, documented, "Resident [#53] passed today approx. (approximately) 0600 (6:00 AM). His body was released to mortuary per family."

The Record of Death, dated 3/17/19 at 6:00 AM, documented Resident #53's principle cause of death was CHF and was signed by the primary care physician.

On 3/28/19 at 5:00 PM, the Clinical Quality Specialist Nurse and DON were present during the interview. The DON stated Resident #53 passed away and the family was okay with his death. The DON stated the nurses should have documented their assessment of Resident #53. The DON reviewed Resident #53's POST form and stated she was not aware his code status was Full Code. The DON stated the facility did not initiate CPR for Resident #53.

On 3/28/19 at 6:10 PM, LPN #4, who admitted Resident #53 to the facility on 2/27/19, stated she received verbal report on 3/17/19 at 6:00 AM from RN #2 Resident #53 had passed away. LPN #4 stated she was told by RN #2 that Resident #53's code status was DNR. LPN #4 stated she did not assess Resident #53 or look in his record to validate his code status. LPN #4 stated when she reviewed and filled out the POST form with Resident #53 on 2/27/19, he was "adamant on being a Full Code."

On 3/28/19 at 6:29 PM, RN #2 stated, on 3/28/19 at 6:29 PM, RN #2 stated, on 3/17/19, she provided verbal report to LPN #4

F 600 days of other residents in the facility will be reviewed by the Center Executive Director or designee on or before 5/21/19 to ensure that there are not any additional allegations noted that require investigation or follow up including ensuring that the code status on the POST form matches the physician order and that the resident's wishes were followed.

Systemic Changes

Center Executive Director and Center Nurse Executive will be educated by Regional Staff on or before 5/21/19 regarding the requirement of the right of residents to be free from abuse, neglect, misappropriation of resident property and exploitation, investigations related to abuse/neglect/misappropriation of resident property/exploitation of residents including investigations of all reported allegations, unexpected deaths and reviews of medical records of patients after a death to ensure that the resident's wishes were followed as documented on the POST form.

Facility staff will be educated on or before 5/21/19 by the Center Executive Director or designee regarding the facility abuse/neglect policy including the right of residents to be free from abuse, neglect, misappropriation of property, and exploitation, the requirement to report all
### F 600

Continued From page 10

when CNA #2 stated Resident #53 was "gone." RN #2 stated she clarified what "gone" meant and her and LPN #4 went to Resident #53's room to assess him. RN #2 stated Resident #53 was pale, his eyes were halfway closed, and he had his arms by his side. RN #2 stated Resident #53 did not have an apical pulse and was not breathing. RN #2 stated she did not look in Resident #53's record for his code status and did not initiate CPR.

On 3/29/19 at 8:35 AM, the Clinical Quality Specialist Nurse and DON were present during the interview. The DON verified she did not know Resident #53's code status was Full Code until she reviewed his POST form on 3/28/19 at 5:00 PM.

On 3/29/19 at 9:29 AM, CNA #2 stated she found Resident #53 in bed on 3/17/19 at 6:15 AM, he was pale and there was no movement in his chest. CNA #2 stated she left the room to notify the nurses. CNA #2 stated she notified RN #2 and the day shift nurse, could not remember who it was, that Resident #53 appeared "passed." CNA #2 stated both nurses went to Resident #53's room, and she assisted other residents. CNA #2 said she did not know what the nurses did from there.

The facility licensed staff neglected to initiate CPR when Resident #53's wishes per his POST form and care plan documented Full Code. This failure may have resulted in his death.

allegations of abuse/neglect, misappropriation of property, and exploitation to the facility Center Executive Director or designee immediately and the requirement to follow the written wishes of a resident as documented on the POST form and verifying that information when a code occurs involving a resident.

Beginning 5/6/19 the Center Executive Director or designee will review reportable investigations and deaths that occur in the facility for completeness including ensuring that all allegations are investigated and that the resident’s wishes were followed as designated on the POST form.

Beginning 5/6/19, the Director of Social Services or designee will review advanced directives and POST status with residents/resident representatives during admission and quarterly care conference meetings and care plan/physician orders will be updated as changes are made.

Monitoring

Beginning the week of 5/22/19, reviews of each reportable investigation and each death that occurs in the facility will be completed at the morning clinical meeting for 12 weeks by the facility interdisciplinary team to ensure
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<td>F 609</td>
<td>Reporting of Alleged Violations</td>
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<td>CFR(s): 483.12(c)(1)(4)</td>
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§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:

§483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care.

Date of Compliance
5/21/19
F 609 Continued From page 12
facilities) in accordance with State law through established procedures.

§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 record review, review of the State Survey Agency’s Reporting Portal, and staff interview, it was determined the facility failed to ensure potential neglect related to the death of a resident when CPR was not initiated per his wishes documented on his POST form were reported to the State Survey Agency within 2 hours. This was true for 1 of 1 resident (Resident #53) who was reviewed for death in the facility. The deficient practice placed the other 52 residents residing in the facility at risk of not having their code status wishes honored if the potential neglect was not reported and investigated. Findings include:

Resident #53 was admitted to the facility on 2/27/19, with multiple diagnoses including congestive heart failure, falls with closed head injury, and current use of anticoagulant medication (blood thinner). Resident #53’s hospital Admission History and Physical, dated 2/24/19 at 3:42 AM, documented he his code status was Full Code and was electronically signed by a Nurse Practitioner.

Resident #53's Initial Nursing Assessment, dated
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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>
<th>COMPLETION DATE</th>
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<tr>
<td>F 609</td>
<td>Continued From page 13 2/27/19, documented he was alert and oriented to person, place, and time. The assessment also documented Resident #53's judgement and insight were intact. Resident #53's POST form, located in his facility record, documented Resuscitate (Full Code) with aggressive interventions for cardiopulmonary resuscitation in the event he did not have a pulse and/or was not breathing. The aggressive interventions included intubation, mechanical ventilation, and that the receiving hospital may admit him to intensive care. Resident #53 signed the POST form on 2/27/19, and the physician signed it on 2/28/19. Resident #53's care plan, dated 3/8/19, documented his code status was &quot;Full Code.&quot; A Nurse's Progress Note, dated 3/17/19 at 10:34 AM, documented, &quot;Resident [#53] passed today approx. (approximately) 0600 (6:00 AM). His body was released to mortuary per family.&quot; Resident #53's record did not include documentation the facility assessed him and initiated CPR per his wishes. The Record of Death, dated 3/17/19 at 6:00 AM, documented Resident #53's principle cause of death was CHF and was signed by the primary care physician. On 3/28/19 at 5:00 PM, the Clinical Quality Specialist Nurse and DON were present during the interview. The DON reviewed Resident #53's POST form and stated she was not aware his code status was Full Code. The DON stated the facility did not initiate CPR for Resident #53.</td>
<td>F 609 A review of their POST/code status will be completed with current interviewable residents on or before 5/21/19 by the Director of Social Services or designee. Any changes in code status will be updated on the POST form, care plan and physician orders obtained. The POA designees or resident representatives of non interviewable residents will be interviewed on or before 5/21/19 by the Director of Social Services or designee regarding any concerns of abuse/neglect. Any concerns of abuse or neglect will be reported and investigated immediately. A review of their POST/code status will be completed with the POA/resident representatives of non interviewable residents on or before 5/21/19 by the Director of Social Services or designee. Any changes in code status will be updated on the care plan, POST form and physician orders obtained. Abuse/neglect investigations and deaths that occurred in the facility for the last 45 days of other residents in the facility will be reviewed by the Center Executive Director or designee on or before 5/21/19 to ensure that there are not any additional allegations noted that require investigation or follow up including ensuring that the code status on the POST form matches the physician order and that the resident’s wishes were followed.</td>
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F 609 Continued From page 14

On 3/28/19 at 6:10 PM, LPN #4, who admitted Resident #53 to the facility on 2/27/19, stated she received a verbal report on 3/17/19 at 6:00 AM, from RN #2 that Resident #53 had passed away. LPN #4 stated she was told by RN #2 Resident #53's code status was DNR. LPN #4 stated she notified Resident #53's son and he stated to her, "to let him go." LPN #4 stated she did not assess Resident #53 or look in his record to validate his code status. LPN #4 stated she documented on Resident #53's neurological assessment flow sheet, "Passed" on 3/17/19 at 6:30 AM. LPN #4 stated when she reviewed and filled out the POST form with Resident #53, he was "adamant on being a Full Code."

The State Survey Agency's Reporting Portal was reviewed on 4/15/19. The portal documented the facility reported the lack of CPR provided to Resident #53 on 3/17/19, on 3/28/19 at 10:30 PM. The incident was not reported within 2 hours of its occurrence.

F 609

Systemic Changes

Center Executive Director and Center Nurse Executive will be educated by Regional Staff on or before 5/21/19 regarding the requirement of investigations related to abuse/neglect including investigations of all reported allegations of abuse/neglect/exploitation or mistreatment including injuries of unknown origin and misappropriation of resident property, investigations of unexpected deaths, thoroughness of investigations, the requirement to report allegations of abuse/neglect/exploitation/or mistreatment to the state agency within 2 hours, investigation results reported to the state agency within 5 working days and reviews of medical records of patients after a death to ensure that the resident's wishes were followed.

Facility staff will be educated on or before 5/21/19 by the Center Executive Director or designee regarding the facility abuse/neglect policy including the requirement to immediately report any allegations of abuse or neglect to the Center Executive Director or designee immediately, results of the investigation must be reported to the state agency within 5 working days and the requirement to follow the written wishes of a resident as documented on the POST form and verifying that information when a
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<td>code occurs involving a resident.</td>
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<td>Beginning 5/6/19, the Center Executive Director or designee will review reportable investigations for completeness including ensuring that all allegations are investigated. Beginning 5/6/19, the Center Executive Director will review deaths that occur in the facility to ensure that the resident's wishes were followed as documented on the POST form.</td>
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Beginning 5/6/19, social services staff or designee will review advanced directives and POST status with residents/resident representatives during quarterly care conference meetings and care plan/physician orders will be updated as changes are made.

Monitoring

Beginning the week of 5/22/19, reviews of each reportable investigation and each death that occurs in the facility will be completed at the morning clinical meeting for 12 weeks by the facility interdisciplinary team to ensure completeness and that the wishes of the resident were followed regarding their code status as documented on the POST form. 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
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<td>re-evaluate the need for further monitoring after 3 months.</td>
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<td>F 610</td>
<td>SS=G</td>
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<td>Investigate/Prevent/Correct Alleged Violation</td>
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<td>Date of Compliance</td>
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<td>CFR(s): §483.12(c)(2)-(4)</td>
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<td>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:</td>
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<td>§483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.</td>
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<td>§483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.</td>
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<td>§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:</td>
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<td>Based on record review and family and staff interview, it was determined the facility failed to initiate or conduct a thorough investigation of potential neglect for 1 of 1 resident (Resident #53) reviewed for death in the facility. When facility staff found Resident #53 unresponsive, CPR was not initiated, as directed in his POST form which documented his code status was</td>
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Resuscitation/Full Code with aggressive interventions. The failure placed the other 52 residents at risk of not having their code status wishes honored if they were unable to communicate them. Findings include:

Resident #53 was admitted to the facility on 2/27/19, with multiple diagnoses including congestive heart failure, falls with closed head injury, and current use of anticoagulant medication (blood thinner). Resident #53’s hospital Admission History and Physical, dated 2/24/19 at 3:42 AM, documented his code status was Full Code and was electronically signed by a Nurse Practitioner.

Resident #53’s Initial Nursing Assessment, dated 2/27/19, documented he was alert and oriented to person, place, and time. The assessment also documented Resident #53’s judgement and insight were intact.

Resident #53’s POST form, located in his facility record, documented Resuscitate (Full Code) with aggressive interventions for cardiopulmonary resuscitation in the event he did not have a pulse and/or was not breathing. The aggressive interventions included intubation, mechanical ventilation, and that the receiving hospital may admit him to intensive care. Resident #53 signed the POST form on 2/27/19, and the physician signed it on 2/28/19.

Resident #53’s March 2019 Physician Orders did not include his code status.

Resident #53’s care plan, dated 3/8/19, documented his code status as "Full Code."

Resident #53 discharged on 3/17/19 from the facility.

Identification of Other Residents

Interviews of residents will be completed on or before 5/21/19 by the Director of Social Services or designee of all current interviewable residents in the facility regarding any concerns of abuse or neglect. Any concerns of abuse or neglect will be reported and investigated immediately.

A review of their POST/code status will be completed with current interviewable residents on or before 5/21/19 by the Director of Social Services or designee. Any changes in code status will be updated on the POST form, care plan and physician orders will be obtained.

The POA designees or resident representatives of non interviewable residents will be interviewed on or before 5/21/19 by the Director of Social Services or designee regarding any concerns of abuse/neglect. Any concerns of abuse or neglect will be reported and investigated immediately. A review of their POST/code status will be completed with the POA/resident representatives of non interviewable residents on or before 5/21/19 by the Director of Social Services.
**F 610** Continued From page 18

A Nurse’s Progress Note, dated 3/17/19 at 10:34 AM, documented, "Resident [#53] passed today approx. (approximately) 0600 (6:00 AM). His body was released to mortuary per family."

The Record of Death, dated 3/17/19 at 6:00 AM, documented Resident #53's principle cause of death was CHF and was signed by the primary care physician.

On 3/28/19 at 5:00 PM, the Clinical Quality Specialist Nurse and DON were present during the interview. The DON stated Resident #53 passed away and the family was okay with his death. The DON stated the nurses should have documented their assessment of Resident #53 when he was found unresponsive. The DON reviewed Resident #53's POST form and stated she was not aware his code status was Full Code. The DON stated the facility did not initiate CPR for Resident #53. The DON stated the coroner was notified for all deaths in the facility if the resident was not receiving hospice services. The DON stated the coroner did an investigation of Resident #53's cause of death and determined it was CHF not from the fall that happened on 3/15/19. The DON said she was not aware she needed to do an investigation when the coroner did one. The Clinical Quality Specialist Nurse stated the facility should have initiated and completed an investigation into why CPR was not initiated for Resident #53 when his POST form documented his code status as Full Code.

On 3/28/19 at 5:47 PM, Resident #53’s son stated Resident #53 had a living will and he was a DNR (Do Not Resuscitate). The son stated he or designee. Any changes in code status will be updated on the care plan, POST form and physician orders obtained.

Abuse/neglect investigations and deaths that occurred in the facility for the last 45 days of other residents in the facility will be reviewed by the Center Executive Director or designee on or before 5/21/19 to ensure that there are not any additional allegations noted that require investigation or follow up including ensuring that the code status on the POST form matches the physician order.

Systemic Changes

Center Executive Director and Center Nurse Executive will be educated by Regional Staff on or before 5/21/19 regarding the requirement of investigations related to abuse/neglect including thoroughness of investigations, preventing further abuse, neglect, exploitation or mistreatment while the investigation is in progress, the requirement to report allegations of abuse/ neglect to the state agency within 2 hours, to report the results of investigations to the state survey agency within 5 working days, and if the alleged violation is verified, appropriate corrective action must be taken.

Facility staff will be educated on or before
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<td>F 610</td>
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<td>F 610</td>
<td>5/21/19 by the Center Executive Director or designee regarding the requirement to immediately report any allegations of abuse, neglect, exploitation or mistreatment to the Center Executive Director or designee, thoroughly investigate all allegations, preventing further abuse, neglect, exploitation, or mistreatment during the investigation and reporting the results of the investigation to the state agency within 5 working days and if the alleged violation is verified, taking appropriate corrective action.</td>
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On 3/28/19 at 6:10 PM, LPN #4, who admitted Resident #53 to the facility on 2/27/19, stated she received a verbal report on 3/17/19 at 6:00 AM, from RN #2 that Resident #53 had passed away. LPN #4 stated she was told by RN #2 Resident #53's code status was DNR. LPN #4 stated she notified his son and he stated to her, "to let him go." LPN #4 stated she did not assess Resident #53 or look in his record to validate his code status. LPN #4 stated she documented on Resident #53's neurological assessment flow sheet, "Passed" on 3/17/19 at 6:30 AM. LPN #4 stated when she reviewed and filled out the POST form with Resident #53, he was "adamant on being a Full Code."

On 3/28/19 at 6:29 PM, RN #2 stated on 3/17/19, she provided verbal report to LPN #4 when CNA #2 stated Resident #53 was "gone." RN #2 stated she clarified what "gone" meant and her and LPN #4 went down to his room to assess him. RN #2 stated Resident #53 was pale, his eyes were halfway closed, and he had his arms by his side. RN #2 stated Resident #53 did not have an apical pulse and was not breathing. RN #2 stated she did not look in his chart for his code status and did not initiate CPR. RN #2 stated the last time she assessed Resident #53 was at 2:30 AM on 3/17/19 when she completed a neurological assessment from a fall he had on 3/15/19 at 3:00 AM. RN #2 documented on the neurological assessment Resident #53 was alert, pupils were equal and reactive to light, had equal

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F 610 did not provide the living will to the facility and was unaware Resident #53's POST form documented his code status as Full Code with aggressive interventions.

On 3/28/19 at 6:10 PM, LPN #4, who admitted Resident #53 to the facility on 2/27/19, stated she received a verbal report on 3/17/19 at 6:00 AM, from RN #2 that Resident #53 had passed away. LPN #4 stated she was told by RN #2 Resident #53's code status was DNR. LPN #4 stated she notified his son and he stated to her, "to let him go." LPN #4 stated she did not assess Resident #53 or look in his record to validate his code status. LPN #4 stated she documented on Resident #53's neurological assessment flow sheet, "Passed" on 3/17/19 at 6:30 AM. LPN #4 stated when she reviewed and filled out the POST form with Resident #53, he was "adamant on being a Full Code."

On 3/28/19 at 6:29 PM, RN #2 stated on 3/17/19, she provided verbal report to LPN #4 when CNA #2 stated Resident #53 was "gone." RN #2 stated she clarified what "gone" meant and her and LPN #4 went down to his room to assess him. RN #2 stated Resident #53 was pale, his eyes were halfway closed, and he had his arms by his side. RN #2 stated Resident #53 did not have an apical pulse and was not breathing. RN #2 stated she did not look in his chart for his code status and did not initiate CPR. RN #2 stated the last time she assessed Resident #53 was at 2:30 AM on 3/17/19 when she completed a neurological assessment from a fall he had on 3/15/19 at 3:00 AM. RN #2 documented on the neurological assessment Resident #53 was alert, pupils were equal and reactive to light, had equal
Continued From page 20

Hand grasps and was able to move all extremities. RN #2 stated the nursing staff were unable to obtain Resident #53's temperature. He was cool and clammy with a stable blood pressure, pulse, and respirations. RN #2 stated the facility's protocol was to notify the coroner for all residents' deaths if they were not on hospice services. RN #2 stated when the assistant coroner came to the facility to assess Resident #53's death, she requested his face sheet and POST form. RN #2 stated that was when she realized he was a Full Code and the assistant coroner went to talk with the son, who was in Resident #53's room. RN #2 stated the assistant coroner returned to the nurse's station and returned the POST form to RN #2 and stated to her that she did not need his POST form. RN #2 stated she notified via phone the DON on 3/17/19, regarding Resident #53 code status being Full Code per his POST form and the facility did not initiate CPR. RN #2 stated on 3/18/19, during the stand-up meeting, the DON instructed the LSW to review all the residents' charts to assure their Advance Directive and POST form matched. RN #2 stated nothing more was discussed or investigated regarding the death of Resident #53 or why CPR was not initiated.

F 610

Death that occurs in the facility will be completed at the morning clinical meeting for 12 weeks by the facility interdisciplinary team to ensure completeness and that the wishes of the resident were followed regarding the code status as documented on the POST form. 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

5/21/19

F 656

Develop/Implement Comprehensive Care Plan

§483.21(b) Comprehensive Care Plans

§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's...
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<td>medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on policy review, record review, observation, and staff interview, it was determined the facility failed to ensure</td>
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<td>Specific Residents Identified</td>
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Comprehensive resident-centered care plans were developed consistent with residents' medical and behavioral needs. This was true for 3 of 16 residents (#18, #27, and #35) reviewed for comprehensive care plans. The residents' care plans included the resident-specific behaviors for the use of psychotropic medications and were not consistent with physician orders. This failure created the potential for harm to residents to receive inappropriate or inadequate care with a subsequent decline in health and/or increased behaviors. Findings include:

The facility's Person-Centered Care Plan policy and procedure, dated 3/1/18, directed staff to develop and implement a comprehensive care plan after completion of the comprehensive assessment for each resident that included measurable objectives and timetables to meet a resident's medical, nursing, nutrition, and mental and psychosocial needs that were identified in the comprehensive assessments.

1. Resident #18 was admitted to the facility on 4/20/18, with multiple diagnoses including aphasia (loss of speech), dysphagia (difficulty swallowing), chronic obstructive pulmonary disease (a progressive lung disease that restricts breathing), right-sided hemiplegia and hemiparesis (paralysis) following cerebral infarction (stroke), and malnutrition.

Resident #18's admission MDS assessment, dated 4/20/18, documented her cognition was severely impaired and she had a feeding tube.

Resident #18's physician orders, dated 4/23/18,

On or before 5/21/19, Residents #27 and #35 will be assessed by the Center Nurse Executive or designee for adverse effects related to care plans not reflecting the resident's current status and physician orders. Follow up will be completed as indicated.

On or before 5/21/19 the Center Nurse Executive or designee will revise Resident #27's care plan and behavior monitoring sheets to reflect her specific signs and symptoms of depression to monitor for use of Celexa and her resident specific behaviors to monitor for the use of Aricept.

Resident #35 was reviewed by the physician on 4/2/19. Lorazepam and Mirtazapine were discontinued on 4/2/19.

Resident #18 was discharged from the facility on 4/26/19.

Identification of Other Residents

On or before 5/21/19, the Center Nurse Executive or designee will review resident care plans for accuracy including specific behavior monitoring. Resident care plans that have identified discrepancies will be revised to reflect the resident's current status and follow up completed by the Center Nurse Executive or designee to reflect resident current status and care
### Statement of Deficiencies and Plan of Correction

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

**Statement of Deficiencies and Plan of Correction**

**Date Survey Completed:**

**Multiple Construction**

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#### Summary Statement of Deficiencies

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#### Resident #18's Weights

Resident #18's weights were documented on the following dates:

- 4/23/18
- 5/2/18
- 5/14/18
- 6/26/18
- 7/24/18
- 8/16/18
- 8/23/18
- 8/30/18
- 9/2/18
- 9/9/18
- 9/16/18
- 10/18/18
- 11/18/18
- 12/2/18
- 1/6/19
- 2/3/19
- 3/3/19

Resident #18 was not weighed weekly as directed by the physician.

On 3/29/19 at 4:55 PM, the DON, with the Clinical Quality Specialist present, reviewed Resident #18's care plan and stated the care plan should have directed staff to monitor her weight weekly per the physician order.

- Resident #18's care plan, dated 4/24/18, directed staff to provide her nutritional needs via enteral tube feeding, and to monitor her weight routinely.

#### Systemic Changes

- On or before 5/21/19, the Center Nurse Executive or designee will educate facility licensed nurses and the interdisciplinary team regarding the facility policy for timely and accurate care plan implementation and revisions.

Beginning 5/6/19, residents will be reviewed by the Center Nurse Executive or designee in daily clinical meeting to ensure resident changes of condition and medication/behavior are reflected accurately on the care plan. Follow up will be completed as indicated.

Beginning 5/6/19, the Center Nurse Executive or designee will review the comprehensive care plan quarterly determined by the MDS Schedule. Any identified discrepancies will be corrected at that time.

#### Monitoring

- Beginning the week of 5/22/19, audits of 5 resident care plans will be reviewed by the Center Nurse Executive or designee to ensure that residents' care plans have been implemented and updated to accurately reflect the resident's current status. Follow up for identified residents will be completed as indicated.
F 656  Continued From page 24

diagnoses including congestive heart failure, dysphasia, aphasia, cerebral infarction (stroke), dementia, depression, bipolar disorder, and Parkinson's Disease.

Resident #27’s physician orders, dated 9/7/18, documented she was prescribed Celexa Tablet 20 mg given by mouth one time a day for depression and Aricept (used to treat dementia) Tablet 10 mg given one by mouth at bedtime for dementia/hallucinations.

Resident #27’s care plan revised on 4/28/18, 10/29/18, and 2/24/19, documented she was at risk for distress and fluctuating mood symptoms related to depression and sadness and was at risk for complications related to the use of psychotropic drugs. Interventions included in the care plan directed staff to monitor Resident #27 for signs and symptoms of worsening sadness and depression, extreme mood swings, impulsive behavior, and paranoia, and to monitor her behaviors. Resident #27’s care plan documented she had a history of hallucinations. Interventions included in the care plan directed staff to watch for hallucinating indicators and report them to nursing and/or social services. Resident #27’s care plan did not describe her specific signs and symptoms of depression to monitor for the use of Celexa and her resident-specific behaviors to monitor for the use of the Aricept.

On 3/28/19 at 3:03 PM, the DON, with the Clinical Quality Specialist present, reviewed Resident #27’s care plan and stated the care plan was initiated by the nurse and should have directed staff to monitor for her specific resident-focused behaviors.

F 656

Audits will be completed weekly x 4 weeks, then monthly x 2 months. 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

5/21/19
3. Resident #35 was admitted to the facility on 2/16/19, with multiple diagnoses including right hip fracture, difficulty walking, muscle wasting and atrophy, dementia, anxiety, and Alzheimer's disease. Resident #35 began hospice care on 3/12/19.

Resident #35's admission MDS assessment, dated 2/23/19, documented her cognition was severely impaired, required one to two-person assist with ADLs, was at risk for falls, and received psychotropic medications.

Resident #35's physician orders, dated 2/16/19 and 3/11/19, documented she was prescribed Lorazepam tablet 0.5 mg one by mouth every six hours as needed for situational anxiety for 90 days, and Mirtazapine (antidepressant also used to treat anxiety) tablet one by mouth at bedtime for dementia.

Resident #35's care plan, dated 2/22/19 and updated 2/24/19 and 3/21/19, documented she was had impaired/decline in cognitive function or thought process related to Alzheimer's disease and dementia, and was at risk for complications related to the use of psychotropic drugs. Interventions included in the care plan directed staff to monitor and evaluate her for mental status and functional level and to report to the physician when indicated. The care plan interventions also directed staff to monitor Resident #35 for wandering, psychiatric disorder, cognitive loss/dementia, delirium, delusions, and hallucinations. Resident #35's care plan care plan did not describe resident-specific behaviors related to anxiety staff were to monitor for the use
### 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>Summary Statement of Deficiencies</th>
<th>ID</th>
<th>Prefix</th>
<th>Tag</th>
<th>Provider's Plan of Correction</th>
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<tr>
<td>F 656</td>
<td>Continued From page 26</td>
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<td>F 667</td>
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<td>Care Plan Timing and Revision</td>
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#### F 656

Continued From page 26

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---

**Regulatory or LSC Identifying Information:**

- **CFR(s):** 483.21(b)(2)(i)-(iii)
- **§483.21(b) Comprehensive Care Plans**
- **§483.21(b)(2) A comprehensive care plan must be-**
  - (i) Developed within 7 days after completion of the comprehensive assessment.
  - (ii) Prepared by an interdisciplinary team, that includes but is not limited to--
    - (A) The attending physician.
    - (B) A registered nurse with responsibility for the resident.
    - (C) A nurse aide with responsibility for the resident.
    - (D) A member of food and nutrition services staff.
    - (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.
    - (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.
  - (iii) Reviewed and revised by the interdisciplinary...
### STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

<table>
<thead>
<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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</table>

**TWIN FALLS CENTER**

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

674 EASTLAND DRIVE

TWIN FALLS, ID 83301

**DATE SURVEY COMPLETED**

04/01/2019

### ID PREFIX TAG

- **F 657** Continued From page 27

  - **F 657**
  
  - **F657**

  - **Specific Residents Identified**

  On or before 5/21/19, Residents #16 and #27 will be assessed by the Center Nurse Executive or designee for adverse effects related to care plans not reflecting the resident's current status and physician orders. Follow up will be completed as indicated.

  On or before 5/21/19 the Center Nurse Executive or designee will revise Resident #16's care plan to accurately reflect the status of a Foley catheter and pressure ulcer.

  On or before 5/21/19, the Center Nurse Executive or designee will revise Resident #27's care plan to accurately reflect the status of a Foley catheter.

  Resident #7 discharged from the facility on 4/16/19. Resident #33 discharged from the facility on 4/10/19.

- **Identification of Other Residents**

  On or before 5/21/19, the Center Nurse Executive or designee will review resident care plans for accuracy. Resident care plans that have identified discrepancies

- **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)

  **COMPLETION DATE**

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1. **Resident #7** was admitted to the facility on 10/15/18, with multiple diagnoses including, breast cancer, and palliative care. Resident #7 began hospice services on admission.

Resident #7's admission MDS assessment, dated 10/22/18, documented her cognition was intact.

Resident #7's care plan, dated 10/15/18,
<table>
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<th>F 657</th>
<th>Continued From page 28</th>
<th>F 657</th>
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<td>documented she was at risk for skin breakdown. A skin integrity report, dated 3/6/19, documented Resident #7 had a Stage II pressure ulcer to her coccyx, which measured 0.3 cm x 0.3 cm and surrounded by non-blanching redness, 7.5 cm x 4 cm x 0.2 cm. Resident #7's care plan did not include the Stage II pressure ulcer to her coccyx and related interventions. On 3/28/19 at 11:20 AM, the WCN stated the care planning for Resident #7 did not get updated with the interventions for wound care for the pressure ulcer that developed on 3/6/19. 2. Resident #16 was readmitted to the facility on 11/8/16, with multiple diagnoses including, pressure ulcer of the left buttock, Resident #16's annual MDS Assessment, dated 11/6/18, documented her cognition was intact. Resident #16's care plan, dated 10/13/18, documented she had an indwelling Foley catheter due to a Stage 4 pressure ulcer in that area. On 3/26/19 at 3:03 PM, Resident #16 was observed sitting in her wheelchair in her room, with no catheter in place. The remainder of Resident #16's record did not document she had a Foley catheter or a pressure ulcer. On 3/29/19 at 4:55 PM, the DON, with the Clinical Quality Specialist present, reviewed Resident #16's care plan, and stated Resident #16's pressure ulcer had resolved and the Foley catheter will be revised to reflect the resident's current status and follow up completed by the Center Nurse Executive or designee to reflect resident current status and care and services provided. Systemic Changes On or before 5/21/19, the Center Nurse Executive or designee will educate facility licensed nurses and the interdisciplinary team regarding the facility policy for timely and accurate care plan revisions. Beginning 5/6/19, residents will be reviewed by the Center Nurse Executive or designee in daily clinical meeting to ensure resident changes of condition and changes in their status are reflected accurately on the care plan. Follow up will be completed as indicated. Beginning 5/6/19, the Center Nurse Executive or designee will review the comprehensive care plan quarterly determined by the MDS Schedule. Any identified discrepancies will be corrected at that time. Monitoring Beginning the week of 5/22/19, audits of 5 resident care plans will be reviewed by the Center Nurse Executive or designee.</td>
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catheter was removed. The DON stated Resident #16's care plan should have been updated.

3. Resident #27 was admitted to the facility on 9/7/18, with multiple diagnoses including congestive heart failure, aphasia (an impairment of language due to brain injury, affecting the production or comprehension of speech and the ability to read or write), cerebral infarction (stroke), dementia, depression, bipolar disorder, and Parkinson's disease.

Resident #27's quarterly MDS assessment, dated 1/17/18, documented her cognition was severely impaired.

Resident #27's care plan, dated 9/12/18, documented she had an indwelling Foley catheter due to urinary retention related to Parkinson's disease.

On 3/25/19 at 3:35 PM, Resident #27 was observed sitting in bed, with no catheter in place.

The remainder of Resident #27's record did not document she had a Foley catheter.

On 3/29/19 at 4:55 PM, the DON, with the Clinical Quality Specialist present, reviewed Resident #27's care plan, and stated Resident #27's Foley catheter was removed 1/31/19, and her care plan should have been updated.

4. Resident #33 was admitted to the facility on 4/23/1996, with multiple diagnoses including a stroke with hemiplegia and hemiparesis (paralysis and weakness to one side of the body)
### F 657

**Continued From page 30**

Affecting his right side.

Resident #33's annual MDS assessment, dated 2/19/19, documented he was severely cognitively impaired and had range of motion impairment to both lower extremities.

On 3/25/19 at 3:30 PM, Resident #33 was observed in bed and his knees bent with contractures.

On 3/25/19 at 3:40 PM, RN #1 stated Resident #33 developed a pressure ulcer to his left inner knee caused by putting pressure on his right inner knee. CNA #4 was observed applying a pillow between Resident #33's knees. CNA #4 stated after Resident #33 developed the pressure ulcer he had been applying a pillow between his knees. CNA #4 stated Resident #33 had been contracted at the knees for a long time.

A Physician's Order, dated 3/25/19, documented licensed staff to cleanse left inner knee with wound cleanser, pat dry, apply Silvasorb (antimicrobial silver hydrogel, to reduce the amount of infectious bacteria) to wound bed, apply skin prep to peri-wound, and cover with a dry dressing every 3 days for an unstageable pressure ulcer.

A Nurse's Progress Note, dated 3/26/19 at 6:53 PM, documented Resident #33 had a 3.0 x 2.0 cm open area with black coloring to 75% of the wound bed/edges.

Resident #33's care plan did not include the need to place a pillow between his knees to prevent further skin damage.
### Summary of Deficiencies

**F 657 Continued From page 31**

On 3/27/19 at 1:42 PM, RN #2 stated Resident #33 developed the unstageable pressure ulcer to his left knee was caused by the Sage boots (heel protector) being poofy, which positioned his knees together and added more pressure.

On 3/28/19 at 10:06 AM, the DON stated Resident #33's care plan did not include nursing staff were to place a pillow between his knees to prevent further skin breakdown.

**F 678 Cardio-Pulmonary Resuscitation (CPR)**

<table>
<thead>
<tr>
<th>CFR(s):</th>
<th>483.24(a)(3)</th>
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§483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives.

This **REQUIREMENT** is not met as evidenced by:

- Based on record review, family and staff interviews, and policy review, it was determined the facility failed to ensure the facility provided CPR per documented instructions and according to the resident's wishes for 1 of 1 resident (Resident #53) whose death record was reviewed. The facility failed to verify Resident #53's code status and initiate lifesaving interventions consistent with his code status, when staff found him unresponsive. The failure to initiate CPR may have contributed to Resident #53's death and placed the health and safety of the 22 other residents residing in the facility, with a code status of Full Code (resuscitate/initiate CPR), in Immediate Jeopardy. Findings include:

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<tr>
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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
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<td>F 678</td>
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<td>5/21/19</td>
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</table>

Specific Residents Identified

- Resident #53 was discharged from the facility on 3/17/19.

Identification of other Residents

- Other residents and/or representatives will be interviewed by the Center Nurse Executive or designee on or before 5/21/19 to determine their wishes for advanced directives. Follow up will be
The facility's Emergency Medical Response policy and procedure, dated 11/28/17, instructed staff to identify the patient's code status, evaluate the patient or resident, and initiate appropriate medical intervention. The facility failed to follow its policy.

Resident #53 was admitted to the facility on 2/27/19, with multiple diagnoses including congestive heart failure (CHF), falls with closed head injury, and current use of anticoagulant medication (blood thinner). Resident #53's hospital Admission History and Physical, dated 2/24/19 at 3:42 AM, documented his code status was Full Code and was electronically signed by a Nurse Practitioner.

Resident #53's POST form, located in his facility record, documented Resuscitate (Full Code) with aggressive interventions for cardiopulmonary resuscitation in the event he did not have a pulse and/or was not breathing. The aggressive interventions included intubation, mechanical ventilation, and that the receiving hospital may admit him to intensive care. Resident #53 signed the POST form on 2/27/19, and the physician signed it on 2/28/19.

Resident #53's March 2019 Physician Orders did not include his code status.

Resident #53's care plan, dated 3/8/19, documented his code status as "Full Code."

A Care Plan Meeting Note, dated 3/14/19 at 12:22 PM, documented an OT, RN, BOM (Business Office Manager), LSW, Resident #53, and his son and daughter-in-law, were in completed including physician notifications, completion of the POST form, obtaining physician orders for code status and care plan updates to accurately reflect the resident's/responsible party's wishes on or before 5/21/19.

Systemic Changes

Facility licensed nursing staff and social services staff will be re-educated by the Center Nurse Executive or designee on or before 5/21/19 on documentation of advanced directive discussions with residents and/or representatives in the medical record, initiation of the Idaho POST form and physician notification to obtain an order for advanced directives, care plan updates to accurately reflect the resident and/or representatives wishes, to locate a resident's code status in the medical record, signs of irreversible death and when to initiate CPR.

On or before 5/21/19, medical emergency drills will be conducted by the Center Nurse Executive or designee two times on each shift for staff competency related to initiation of CPR for those residents that desire to be full code.

Beginning 5/6/19, the Director of Social Services or designee will review advanced directives and POST status with residents/representatives during quarterly care conference meetings and
The summary of the meeting documented, "Reviewed progress in therapy and medications. Discussed discharge plan/date. Family desire to honor resident's wishes and make it possible for resident to return home with support from [Name of Hospice]. Discharge is scheduled for Tuesday. No concerns at this time and all questions have been answered. Advance directive reviewed (yes/no): No." The note was documented by the LSW.

A Nurse's Progress Note, dated 3/17/19 at 10:34 AM, documented, "Resident [#53] passed today approx.(approximately) 0600 (6:00 AM). His body was released to mortuary per family." Resident #53's record did not include documentation the facility assessed him or initiated CPR per his wishes.

The Record of Death, dated 3/17/19 at 6:00 AM, documented Resident #53's principle cause of death was CHF and was signed by the primary care physician.

On 3/28/19 at 5:00 PM, the Clinical Quality Specialist Nurse and DON were present during the interview. The DON stated Resident #53 passed away and the family was okay with his death. The DON stated the nurses should have documented their assessment of Resident #53. The DON reviewed Resident #53's POST form and stated she was not aware his code status was Full Code. The DON stated her expectations, and the facility's protocol, was for the licensed staff to assess the resident, review the code status in the resident's record, and initiate CPR if the resident had a code status of Full Code. The DON stated the facility did not care plan/physician orders will be updated as changes are made.

Beginning 5/6/19, new admission charts will be reviewed in the morning clinical meeting by the Interdisciplinary team to ensure that the POST form is completed, physician orders are obtained and the care plan accurately reflects the resident/representative’s wishes regarding code status.

Beginning 5/6/19, the Center Executive Director will review deaths that occur in the facility to ensure that the residents wishes were followed as documented on the POST form.

Monitoring

Beginning the week of 5/22/19, audits will be completed weekly for 12 weeks of 5 resident records to ensure that the POST, physician orders, and care plans accurately reflect the resident/representative’s wishes regarding code status.

Beginning the week of 5/22/19, reviews of each death that occurs in the facility will be completed at the morning clinical meeting for 12 weeks by the facility interdisciplinary team to ensure that the wishes of the resident were followed regarding their code status as documented on the POST form.
<table>
<thead>
<tr>
<th>(X4) ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>(X5) COMPLETION DATE</th>
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<tbody>
<tr>
<td>F 678</td>
<td>Continued From page 34 initiate CPR for Resident #53. The DON stated the coroner was notified for all deaths in the facility if the resident was not receiving hospice services. On 3/28/19 at 5:47 PM, Resident #53’s son stated Resident #53 had a living will and his code status was Do Not Resuscitate (DNR). Resident #53’s son stated he did not provide the living will to the facility and was unaware Resident #53’s POST form documented a code status of Full Code with aggressive interventions. On 3/28/19 at 6:10 PM, LPN #4, who admitted Resident #53 to the facility on 2/27/19, stated she received a verbal report on 3/17/19 at 6:00 AM, from RN #2 that Resident #53 had passed away. LPN #4 stated she was told by RN #2 resident #53’s code status was DNR. LPN #4 stated she notified his son and he stated to her, “to let him go.” LPN #4 stated she did not assess Resident #53 or look in his record to validate his code status. LPN #4 stated she documented on Resident #53’s neurological assessment flow sheet, “Passed” on 3/17/19 at 6:30 AM. LPN #4 stated when she reviewed and filled out the POST form with Resident #53, he was &quot;adamant on being a Full Code.&quot; On 3/28/19 at 6:29 PM, RN #2 stated on 3/14/19, she and the LSW attended a care conference with Resident #53 and his family, regarding their wishes for Resident #53 to be discharged home with hospice services on 3/19/19. RN #2 stated on 3/17/19, she provided a verbal report to LPN #4 when CNA #2 stated Resident #53 was &quot;gone.&quot; RN #2 stated she clarified what &quot;gone&quot; meant and her and LPN #4 went down to his</td>
<td>F 678</td>
<td>Beginning the week of 5/22/19, medical emergency drills will be conducted by the Center Nurse Executive or designee weekly x 4 weeks, then monthly x 2 months for staff competency related to initiation of CPR for those residents that desire to be full code. Results of the audits will be reported to the QAPI committee monthly for 3 months for review and remedial intervention. The Center Nurse Executive is responsible for monitoring and compliance. The QAPI Committee will re-evaluate the need for further monitoring after 3 months.</td>
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### Statement of Deficiencies and Plan of Correction

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

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<td>Continued From page 35</td>
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<td>Room to assess him. RN #2 stated Resident #53 was pale, his eyes were halfway closed, and he had his arms by his side. RN #2 stated Resident #53 did not have an apical pulse (heart beat) and was not breathing. RN #2 stated she did not look in his record for his code status and did not initiate CPR. RN #2 stated the last time she assessed Resident #53 was at 2:30 AM on 3/17/19, when she completed a neurological assessment from a fall he had on 3/15/19 at 3:00 AM. RN #2 documented on the neurological assessment Resident #53 was alert, pupils were equal and reactive to light, he had equal hand grasps, and was able to move all extremities. RN #2 stated at the time of the neurological assessment the nursing staff were unable to obtain Resident #53's temperature, however, his blood pressure, pulse, and respirations were stable. RN #2 stated the facility's protocol was to notify the coroner for all residents' deaths if they were not on hospice services. RN #2 stated when the assistant coroner came to the facility to assess Resident #53's death and requested his face sheet and POST form. RN #2 stated that was when she realized Resident #53's code status was Full Code and the assistant coroner went to talk with the son, who was in Resident #53's room. RN #2 stated the assistant coroner returned to the nurse's station and returned the POST form to RN #2 and stated to her that she did not need his POST form. RN #2 stated she notified the DON via phone on 3/17/19, that Resident #53's code status was Full Code per his POST form and the facility did not initiate CPR. RN #2 stated that on 3/18/19 during the stand-up meeting, the DON instructed the LSW to review all the residents' records to assure their Advance Directive and POST forms matched. RN #2</td>
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stated nothing more was discussed or investigated regarding the death of Resident #53.

On 3/28/19 at 6:58 PM, the LSW stated Resident #53 had a care conference on 3/14/19. The LSW stated herself, RN #2, Business Office Manager, Resident #53, and his son and daughter-in-law were present during the care conference. The LSW stated the care conference was regarding Resident #53 being discharged home with hospice services on 3/19/19. The LSW stated she did not review his Advance Directives or his POST form with Resident #53 or the family.

On 3/29/19 at 8:35 AM, the Clinical Quality Specialist Nurse and DON were present during the interview. The DON verified she did not know Resident #53 was a Full Code until she reviewed his POST form on 3/28/19 at 5:00 PM.

On 3/29/19 at 9:29 AM, CNA #2 stated when she found Resident #53 on 3/17/19 at 6:15 AM, he was pale and there was no movement in his chest. CNA #2 stated she was with another CNA and left the room to notify the nurses. CNA #2 stated she notified RN #2 and the day shift nurse, could not remember who it was, that Resident #53 appeared "passed." CNA #2 stated both nurses went to Resident #53's room and she assisted other residents and did not know what the nurses did from there.

On 3/29/19 at 10:20 AM, CNA #3 stated she worked the night shift, on 3/16/19 at 6:00 PM until 3/17/19 at 6:30 AM. CNA #3 stated she assisted Resident #53 to the bathroom, on 3/17/19 at 5:00 AM, and he was alert and awake. CNA #3 stated Resident #53 was on 30 minute checks at the
### Statement of Deficiencies and Plan of Correction

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

135104

**Date Survey Completed:**

04/01/2019

**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 678</td>
<td>Continued From page 37 time, following a fall he had on 3/15/19. CNA #3 stated what Resident #53 was doing at the time of each 30 minute check was documented. The facility provided a 24 hour, 30-minute check form, dated 3/16/19, for Resident #53. On 3/17/19 at 5:00 AM, CNA #3 documented Resident #53 was in bed and awake. The 30-minute check form was blank for the 5:30 AM check. At 6:00 AM and 6:30 AM, the 30-minute check form documented, &quot;Bed&quot; without initials. At 7:00 AM, the form documented he was in the &quot;w/c (wheelchair).&quot; Resident #53's record documented he passed on 3/17/19 at 6:00 AM. Removal of Immediate Jeopardy: On 3/29/19 at 4:02 PM, the Administrator, DON, Nurse Practice Educator, and Clinical Quality Specialist Nurse were informed verbally and in writing of the immediate jeopardy. On 3/29/19 at 4:53 PM, the Clinical Quality Specialist Nurse provided a plan to remove the immediate jeopardy. The facility's plan to remove the immediate jeopardy was: * Residents and/or responsible parties were interviewed and each resident's code status was verified. * Physician orders were obtained for residents' code status. * Care plans were updated to reflect the residents' wishes for their code status.</td>
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This document contains a summary of deficiencies found during a survey of the facility, along with the provider's plan of correction for each deficiency. The plan includes actions such as interviewing residents and responsible parties, obtaining physician orders, and updating care plans to reflect residents' wishes for their code status. The removal of immediate jeopardy was achieved through these corrective actions, ensuring the residents' safety and well-being were prioritized.
F 678 Continued From page 38

* In-service education for all employees to locate a resident's code status in the record under the Advance Directive tab.

* In-service education to all licensed staff, which began on 3/28/19, regarding:

  a. Documentation of Advance Directives including POST Form.

  b. Managing Cardiac/Respiratory Arrest Policy and Procedure when discovery of a patient with no pulse, no blood pressure, no respirations staff immediately: determine if Full Code or DNR in the resident's record if a resident's code status is Full Code initiate CPR.

  c. Advance Directive/POST form quiz to be completed by each licensed staff prior to starting their next scheduled shift. Each in-serviced staff member was given a copy of the policy and procedure and required to sign the in-service was completed.

On 3/29/19 at 6:15 PM, the Clinical Quality Specialist Nurse and the Administrator were informed the plan was acceptable to remove the immediate jeopardy.

Implementation of the above corrective actions was verified by the survey team prior to the team leaving the facility on march 29, 2019.

F 684 Quality of Care

CFR(s): 483.25

§ 483.25 Quality of care

Quality of care is a fundamental principle that applies to all treatment and care provided to
F 684 Continued From page 39

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 policy review, record review, and staff interview, it was determined the facility failed to follow physician orders related to the frequency of obtaining residents' weights. This was true for 2 of 3 residents (#18 and #27) reviewed for nutrition. This failed practice had the potential for harm to residents whose care and services were not delivered according to accepted standard of clinical practices. Findings include:

The facility's Weights and Heights policy and procedure, dated 8/1/18, directed staff to obtain weights of residents on admission and/or readmission, then weekly for four weeks and monthly thereafter, and annually. Additional weights may be obtained at the discretion of the interdisciplinary care team.

1. Resident #18 was admitted to the facility on 4/20/18, with multiple diagnoses including aphasia (an impairment of language due to brain injury, affecting the production or comprehension of speech and the ability to read or write), chronic obstructive pulmonary disease (progressive lung diseases characterized by increasing breathlessness), right-sided hemiplegia and hemiparesis (paralysis) following cerebral infarction (stroke), and malnutrition.

Resident #18's admission MDS assessment,

F 684
Specific Residents Identified

Resident #18 was discharged on 4/26/19.

Resident #27 was assessed by the Center Nurse Executive on or before 5/21/19 for any negative effects related to not following physician orders. Current physician orders were reviewed for the last 30 days for potential omissions by the Center Nurse Executive or designee. Any identified issues were addressed.

Resident #27's weight was obtained on or before 5/21/19 and documented in the medical record. The Interdisciplinary team will review the nutritional and weight status of resident #27 and make recommendations to her physician as indicated on or before 5/21/19. The Center Nurse Executive or designee will follow up on any new orders.

Identification of Other Residents

Other resident's current physician orders were reviewed for potential
F 684 Continued From page 40 dated 4/20/18, documented her cognition was severely impaired, and she had a feeding tube.

Resident #18's physician orders, dated 4/23/18, documented she was to be weighed weekly.

Resident #18's Weight and Vitals Summary Record, dated 4/23/18 through 3/3/19, did not document her weight was consistently assessed weekly. Resident #18's weights were documented as follows:

* April 2018 - 4/23/18
* May 2018 - 5/2/18 and 5/14/18
* June 2018 - 6/26/18
* July 2018 - 7/24/18
* August 2018 - 8/16/18, 8/23/18, and 8/30/18
* September 2018 - 9/2/18, 9/9/18, and 9/16/18
* October 2018 - 10/18/18
* November 2018 - 11/18/18
* December 2018 - 12/2/18
* January 2019 - 1/6/19
* February 2019 - 2/3/19
* March 2019 - 3/3/19

Resident #18's weight was not assessed weekly as directed by the physician.

On 3/28/19 at 3:03 PM, the DON, with the Clinical Quality Specialist present, reviewed the weights, physician orders, and care plans of Resident #18 and stated weights were monitored per physician orders and facility protocol, and if the resident's weights were stable, the Dietician recommended a change in the physician's order for less frequent monitoring.

On 3/29/19 at 4:10 PM, the DON, with the errors by the Center Nurse Executive or Designee on or before 5/21/19. Any identified errors will be addressed and followed up on by the Center Nurse Executive.

Current residents' weights will be obtained according to physician orders and documented in the medical record by the Center Nurse Executive or designee on or before 5/21/19. The registered dietician was notified and reviewed current weights in order to identify any significant changes. For residents with significant weight changes, the registered dietician assessed the resident and provided recommendations to the primary care physician on or before 5/21/19. The Center Nurse Executive or designee followed up on any new orders.

Systemic Changes

The facility reviewed the process for obtaining weights notification to the registered dietician and documenting in the medical record on or before 5/21/19. It was determined that the facility did not maintain adequate communication between departments. Beginning on 5/6/19, the Center Nurse Executive will maintain a master weight list for current residents which will improve communication with nursing staff and the registered dietician.

Beginning the week of 5/6/19, in the
### Continued From page 41

Clinical Quality Specialist present, reviewed the progress notes, physician orders, and weights, and stated physician orders for monitoring Resident #18’s weight weekly was not followed and there was no recommendation made to the physician to change the frequency of her weight monitoring.

2. Resident #27 was readmitted to the facility on 9/7/18, with multiple diagnoses including congestive heart failure, dysphasia, aphasia, cerebral infarction (stroke), dementia, depression, bipolar disorder, and Parkinson's Disease.

Resident #27’s quarterly MDS assessment, dated 10/17/18, documented her cognition was intact.

Resident #27’s physician orders, dated 9/7/18, documented she was to be weighed daily and to notify the physician of a weight gain of three or more pounds in one day or five or more pounds in one week related to congestive heart failure.

Resident #27’s Weights and Vitals Summary Record, dated 12/31/18 through 3/27/19, did not document her weight was assessed daily. Resident #27 was not weighed on the following dates.

* January - 1/11/19, 1/14/19, 1/18/19, 1/19/19, 1/25/19, and 1/28/19 - 1/31/19
* February - 2/8/19, 2/9/19, 2/12/19 - 2/14/19, 2/17/19, 2/18/19, 2/22/19 - 2/26/19, and 2/28/19
* March - 3/4/19 and 3/6/19 - 3/19/19

### WEEKLY CLINICAL AT RISK MEETING

Beginning the week of 5/22/19, the Center Nurse Executive or designee will assess/audit 5 resident’s physician’s orders for weight management to ensure that the orders are followed. These audits will be completed weekly X 4 weeks and then monthly X 2 months. The results of these audits will be reported to the center QAPI committee for review and remedial intervention monthly for 3 months. 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**

5/21/19
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<tr>
<td>F 684</td>
<td></td>
<td></td>
<td>Continued From page 42 On 3/28/19 at 3:03 PM, the DON, with the Clinical Quality Specialist present, reviewed the weights, physician orders, and care plan of Resident #27 and stated her weights were not monitored per the physician orders. The DON stated Resident #27’s weight should be monitored daily.</td>
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<td>F 686</td>
<td>SS=G</td>
<td>Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)</td>
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<td>F 686 Specific Residents Identified F 686 Resident # 7 discharged on 4/16/19 F 686 Resident # 33 discharged on 4/10/19 F 686 Identification of Other Residents F 686 Other Facility residents will have a skin assessment completed by a licensed</td>
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The facility's Skin Integrity Management policy, revised 11/28/16, documented, "The implementation of an individual patient's skin integrity management occurs within the care delivery process. Staff continually observes and monitors patients for changes and implements revisions to the plan of care as needed." The policy also included the following:

* Identify patient's skin integrity status and need for prevention interventions or treatment modalities through review of all appropriate assessment information.

* Develop comprehensive, interdisciplinary plan of care including prevention and wound treatments, as indicated.

* Review co-morbid conditions that may affect healing.

* Notify Dietitian and/or rehabilitation services as indicated.

* Notify physician to obtain orders.

* Notify patient, family, health care decision maker of plan of care.

* Review care plan weekly and revise as indicated.

* Document daily monitoring of ulcer site, with or without dressing.

This policy was not followed.

1. **Resident #33** was admitted to the facility on **nurse for any previously unidentified skin issues on or before 5/21/19.** Follow-up including physician notification, treatment, and care plan updates will be completed as indicated.

A review of current resident's skin risk factors including but not limited to incontinence, immobility, medical device use, impaired skin sensitivity, or poor nutritional status will be completed by the Center Nurse Executive or designee on or before 05/21/19. Follow-up will be completed including but not limited to additional assessments, physician notification, and care plan/ Kardex updates as indicated.

Residents who are dependent on staff for positioning in the supine, side lying, and sitting position as indicated by resident condition will be reviewed by the Center Nurse Executive or designee for any previously unidentified pressure source on or before 5/21/19. Follow-up intervention to reduce pressure and modifications to resident skin at risk care plans will be updated as indicated by the review.

Residents will be reviewed by the Center Nurse Executive or designee to ensure that they have a skin at risk care plan in place that is based on resident individualized risk factors for skin breakdown on or before 5/21/19. A review of resident's pressure support surfaces will be completed by the Center Nurse.
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<td>4/23/1996, with multiple diagnoses including a stroke with hemiplegia and hemiparesis (paralysis and weakness to one side of the body) affecting his right side.</td>
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<td>Resident #33's at risk for skin breakdown care plan, dated 9/17/14, included interventions for a Low Air Loss mattress with bolsters, pressure redistribution surfaces to chair, turn and re-position every 2 hours and as needed, float heels while in bed with pillows, observe skin conditions with ADL care, observe skin for signs/symptoms of skin breakdown, and weekly skin checks by the licensed nurse.</td>
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<td>A facility Guideline for the Low Air Loss mattress, undated, documented, &quot;Warning! Do not use as an intervention for heel ulcers. At risk and actual heel wounds should be off the bed surface (off-loaded using a pillow or heel-lift type of device).&quot;</td>
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<td>Resident #33's actual skin breakdown care plan, dated 11/13/18, included interventions for Sage boots (heel protectors) to be worn to bilateral lower extremities (BLE) while in bed.</td>
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<td>A Significant Change Braden Scale (a tool used to assess a resident's risk for developing pressure ulcers) assessment, dated 1/20/19, documented Resident #33 was at moderate risk for developing a pressure ulcer.</td>
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<td>Resident #33's annual MDS assessment, dated 2/19/19, documented he was severely cognitively impaired and required extensive assistance of two staff members for bed mobility and transfers. The MDS documented Resident #33 was at risk</td>
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<td>Executive or designee to ensure that residents have the optimal surface for comfort and pressure reduction, and that air surfaces are inflated per resident specific need/manufacturer recommendation on or before 5/21/19. Follow-up including bed/surface modifications, physician's orders, and or care plan/ Kardex updates will be completed by the Center Nurse Executive or designee on or before 5/21/19. Residents who require air mattresses will have the functioning of the air mattress assessed by the Director of Maintenance or designee on or before 5/21/19. Any malfunctioning mattress will be immediately removed from service and replaced with a functional mattress.</td>
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<td>Licensed nurses will be re-educated on pressure ulcer assessment, treatment, skin assessment, and risk factors, support surface selection and monitoring requirements by the Center Nurse Executive or designee on or before 5/21/19.</td>
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<td>Licensed nurses will have a skin assessment competency completed on or before 5/21/19 by the Center Nurse Executive or designee.</td>
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<td>Direct care staff will be re-educated on pressure ulcer prevention, resident risk factors, skin checks, and other</td>
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### 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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<th>ID</th>
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<th>Summary Statement of Deficiencies</th>
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<th>Provider's Plan of Correction</th>
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| F 686 | Continued From page 45 | for pressure ulcers and had one unstageable pressure with slough (non-viable tissue due to reduced blood supply) and/or eschar (black, necrotic, dead tissue). According to the Johns Hopkins Medicine website, accessed on 4/17/19, an unstageable pressure ulcer is full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown in color) and/or eschar (tan, brown or black) in the wound bed.  

  a. An SBAR (Situation, Background, Appearance, Review and Notify) Communication Form, dated 11/13/18, documented Resident #33 had an abrasion to his right ankle. Sage boots were initiated to BLE while he was in bed.  

  An SBAR Communication Form, dated 11/21/18, documented Resident #33 had a persistent red area with measurements of 6.0 cm x 5.0 cm to his right heel. The form stated within the reddened area was an intact blister. The measurements of the blister were documented as 3.0 cm x 2.0 cm. The form documented licensed staff were to apply skin prep (a liquid which forms a protective film or barrier) to the wound and cover with a foam dressing.  

  An Incident and Accident Report, dated 11/21/18 at 7:00 AM, documented a new in-house acquired pressure ulcer to Resident #33’s right heel. A witness statement by a CNA documented she noticed a pressure ulcer to Resident #33’s heel and notified the nurse. The statement did not identify which heel had the pressure ulcer.  

  Resident #33’s Weekly Skin Checks, dated 11/16/18 through 12/14/18, did not include components of the Genesis Skin Integrity Framework on or before 5/21/19 by the Center Nurse Executive or designee. A post test for competency of the skin integrity framework will be completed by the Center Nurse Executive or designee on or before 5/21/19.  

  A new center wound care champion/coordinator will be assigned to oversee the center skin program on or before 5/21/19. The new identified wound champion will be educated on the Genesis Skin Integrity framework by a Genesis wound care specialist on or before 5/21/19.  

  Center staff will be educated on or before 5/21/19 on the stop and watch tool used to identify and report any new areas of concern such as skin redness or changes in resident condition for follow-up nursing assessment.  

  Beginning 5/6/19, residents who are newly admitted to the center/ readmissions, and residents with noted change of condition will have their skin at risk care plan reviewed in morning clinical meeting for any required updates to resident care plan/ Kardex.  

  Monitoring  

  5 residents at risk for skin breakdown will be audited by the Center Nurse Executive or designee on or before 5/21/19 to ensure risk factors for pressure injury are...
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| F 686 | Continued From page 46 | documentation of the pressure ulcer to Resident #33's right heel which was identified on 11/21/18. Subsequent skin checks were as follows:
| | | |- A Weekly Skin Check, dated 12/21/18, documented Resident #33 had a pressure ulcer to his right heel and left lower extremity (LLE). There was no documentation of measurements and/or a description of the appearances of the pressure ulcer to the right heel or the LLE.
| | | |- The Weekly Skin Checks, dated 12/29/18 and 1/5/19, documented Resident #33 had a pressure ulcer to his right heel with no measurements or description of the appearance of the pressure ulcer. There was no documentation about the LLE pressure ulcer.
| | | |- The Weekly Skin Checks, dated 1/13/19 and 1/19/19, documented Resident #33 had a pressure ulcer to his left heel, which was not previously identified in documentation, and the dressing was dry and intact. The skin checks did not include appearance or measurements of the pressure ulcer. There was no documentation of the right heel and the LLE pressure ulcers.
| | | | The TAR's for Resident #33 for November 2018 to March 2019 documented the following:
| | | |- Resident #33's November 2018 TAR, dated 11/20/18, documented licensed staff applied skin prep and a foam dressing to his right heel pressure ulcer every 3 days. The licensed staff were to ensure Sage boots were on Resident #33's BLE when he was in bed twice a day.
| | | |- Resident #33's December 2018 TAR

F 686 identified, and that interventions are implemented per the plan of care. These audits will be completed weekly X 4 weeks and then monthly x 2 months. The results of these audits will be reported to the QAPI committee for review and remedial intervention monthly X3 months. 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
5/21/19
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<td>F 686</td>
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<td>Documented licensed staff were to ensure Sage boots were on Resident #33's BLE when he was in bed twice a day. The December 2018 TAR did not include documentation on 12/7/18, 12/11/18, 12/15/18, and 12/16/18 the Sage boots were on Resident #33 as directed.</td>
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<td>- Resident #33's December 2018 TAR documented licensed staff were to float heels with pillows while in bed every night shift. The December 2018 TAR did not include documentation Resident #33's heels were floated as directed on 12/7/18, 12/15/18, and 12/16/18.</td>
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<td>- Resident #33's January 2019 TAR included orders for licensed staff to apply Sage boots to BLE while in bed every night shift. The January 2019 TAR documented licensed staff were to float heels with pillows when in bed every night shift. The January 2019 TAR did not include documentation on 1/3/19, 1/8/19-1/11/19, 1/14/19-1/16/19, and 1/17/19, these were completed.</td>
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<td>- Resident #33's January 2019 TAR documented licensed staff were to apply skin prep and foam dressing to Resident #33's pressure ulcer to the left heel every 3 days. There was no documentation on 1/10/19, 1/13/19, 1/16/19, 1/19/19, 1/22/19, 1/25/19, 1/28/19, and 1/31/19, this was completed.</td>
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<td>- Resident #33's January 2019 TAR included a physician's order, dated 1/10/19 through 1/15/19, for licensed staff to apply a wet to dry dressing daily to his left heel. A physician's order, dated 1/16/19, stated licensed staff were to leave the dressing to the left foot clean, dry, and intact until his next podiatry appointment.</td>
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F 686 Continued From page 48

- Resident #33's February 2019 TAR, dated 2/1/19 to 2/21/19, documented licensed staff were to leave the dressing to the left foot clean, dry, and intact. On 2/21/19, the TAR documented licensed staff were to change the dressing to his left heel twice a day using a wet to dry gauze and secure with Kerlix (cotton wrap). The February 2019 TAR did not include documentation the treatment was completed on 2/23/19, 2/24/19, and 2/28/19.

A Physician's Order, dated 1/2/19, documented Resident #33 was referred to podiatry for care of the unstageable pressure ulcer to his left heel. The podiary notes were as follows:

- An initial assessment Podiatrist Progress Note, dated 1/9/19, documented Resident #33 had a Stage III pressure ulcer to his left heel. According to the Johns Hopkins Medicine website, accessed 4/17/19, a Stage III pressure ulcer is full thickness skin loss and slough may be present but does not obscure the depth of tissue loss and the ulcer may have undermining/tunneling. The measurements of the ulcer were 5.0 cm x 5.0 cm x 0.3 cm. The podiatrist documented the ulcer had a foul smell, slough, and drainage. The progress note documented Resident #33 was very contracted in his lower extremities and the facility recently applied heel boots for protection. The left heel pressure ulcer was debrided (removal of the dead tissue) to ensure adequate healing, reduce risk of infection, and improve overall health of the pressure ulcer.

- A Podiatrist Progress Note, dated 1/16/19,
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<td>F 686</td>
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<td>Continued From page 49 documented Resident #33 had Methicillin-resistant Staphylococcus aureus (MRSA) in the left heel ulcer and oral antibiotics were started. The left heel pressure ulcer measurements were 5.0 cm x 5.0 cm x 0.3 cm. The progress note documented the pressure ulcer had a foul smell, slough, and drainage with &quot;mushy&quot; eschar on part of the wound. - A Podiatrist Progress Note, dated 1/25/19, documented Resident #33 was going to continue with oral antibiotics for the infection to his left foot ulcer. The left heel wound measurements were 4.9 x 5.0 x 0.3 cm. The wound characteristics documented foul smell had improved some, slough, and drainage. - A Podiatrist Progress Note, dated 2/6/19, documented the left heel pressure ulcer measurement was 4.9 cm x 4.9 cm x 0.3 cm with the entire wound being covered with a dry eschar present, continued mushiness on the distal wound. A new superficial blister with intact skin underneath was present. The progress note documented the foul smell and the infection were improving and will continue with the antibiotics for another 14 days. - A Podiatrist Progress Note, dated 2/21/19, documented Resident #33 was supposed to have x-rays on 2/13/19 to his left heel. The Podiatrist stated the x-rays were not completed as ordered. The Podiatrist ordered the x-rays again to rule out a bone infection. The progress note documented the Podiatrist spoke to Resident #33's primary care physician to start IV antibiotics. Resident #33's record did not include IV antibiotics were initiated.</td>
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### SUMMARY STATEMENT OF DEFICIENCIES

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- A Podiatrist Progress Note, dated 3/5/19, documented the left heel pressure ulcer had worsened. The measurements were 4.9 cm x 6.4 cm x 0.5 cm with improved odor. The wound base was covered with wet eschar and continued "mushiness" that was worsening and some purulent (fluid containing pus) drainage.

- A Podiatrist Progress Note, dated 3/12/19, documented the left heel pressure ulcer was worse at every visit. The measurements were 5.5 cm x 7.3 cm x 1.5 cm. The podiatrist documented the foul odor was much worse on this visit with significant discolored drainage which was purulent in nature. The mushiness was worsening and the wound was deepening. The podiatrist documented he was going to notify Resident #33's primary care physician for a plan. The progress note documented the wound was worsening rapidly and he feared Resident #33 may get sepsis (bacterial infection in the bloodstream). The podiatrist referred Resident #33 to a vascular surgeon or orthopedic for possible below the knee amputation (BKA).

- A Podiatrist Progress Note, dated 3/19/19, documented the left heel continued to worsen at every visit. The wound measurements are 5.8 cm x 7.8 cm x 1.7 cm, most of the wound was covered with a wet eschar. The progress note documented the podiatrist was still trying to reach Resident #33's primary care physician to refer him for a bone scan and a vascular surgeon or orthopedic surgeon for consult.

On 3/25/19 at 3:30 PM, RN #1 and CNA #4 were observed wearing gowns and gloves, while RN
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<td>#1 was providing wound care to Resident #33's left heel. RN #1 stated he had MRSA in his left heel. RN #1 stated Resident #33 had the pressure ulcer for quite a while. RN #1 was observed removing the dressing to Resident #33's left heel. RN #1 was attempting to remove the dressing to his left heel wound without success, then after several unsuccessful attempts, while Resident #33 was hollering out in pain and flinching his left leg in pain, she used wound cleanser to moisten the dried dressing, and then it removed easily from his wound. RN #1 applied two sprays of wound cleanser to the 4 x 4 clean gauze, applied it to his left heel, then applied dry 4 x 4 gauze over the moist gauze, then wrapped his left foot with Kerlix for security. RN #1 stated the dressing was not to be too moist for the wet to moist dressing.</td>
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<td>On 3/26/19 at 3:20 PM, the Wound Nurse/RN #2 was observed providing wound care to Resident #33's left heel. RN #2 removed the Kerlix dressing, then moistened the dirty 4 x 4 gauze from the wound bed to remove without Resident #33 experiencing pain. RN #2 removed her gloves, washed her hands, and applied a new pair of gloves. RN #2 described Resident #33's left heel wound as pale granulation, slough with moist eschar, and moderate serosanguineous drainage. The measurements were 6.0 x 8.5 x 1.0 cm. RN #2 stated Resident #33's left heel was debrided by a podiatrist back in January and continued with the same wet to dry dressing change and the wound became worse.</td>
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<td>On 3/27/19 at 1:20 PM, RN #2 stated Resident #33 developed a blister to his left heel, on 11/21/18, and the nurses were documenting that</td>
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**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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**NAME OF PROVIDER OR SUPPLIER**

**TWIN FALLS CENTER**

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

674 EASTLAND DRIVE

TWIN FALLS, ID 83301

**PROVIDER'S PLAN OF CORRECTION**

(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

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**Continued From page 52**

it was his right heel when it should have been his left heel. RN #2 stated the Sage boots were initiated on 11/13/18 when Resident #33 developed an abrasion to his right ankle. RN #2 stated the blanks in the TARs meant the treatment was not completed. RN #2 stated she was the Wound Care Nurse up to November 2018 and then was the ADON (Assistant Director of Nursing) and the facility identified in February 2019 residents' were developing facility acquired pressure ulcers and was switched back to the Wound Care Nurse in March 2019. RN #2 stated the floor nurses were responsible for the wound care and the weekly skin checks. RN #2 stated she did the weekly skin assessments and measurements. RN #2 stated Resident #33's unstageable pressure ulcer to his left heel was facility acquired and should have been prevented.

b. A Weekly Skin Check, dated 1/13/19 and 1/19/19, documented Resident #33 had a moisture associated skin damage to his sacrum. There were no measurements documented or a description of the appearance of the skin damage to Resident #33's sacrum.

A Weekly Skin Check, dated 2/3/19, documented Resident #33 had moisture associated skin damage with blanchable redness to his sacrum. There were no measurements documented.

A Weekly Skin Check, dated 2/22/19, documented Resident #33 had an open area to his sacrum. There were no measurements documented or a description of the appearance of the open area.
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<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
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<td>A Weekly Skin Check, dated 3/1/19, documented Resident #33 had a pressure ulcer to his sacrum. There were no measurements documented or description of the appearance of the pressure ulcer.</td>
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<td>A Weekly Skin Check, dated 3/8/19, documented Resident #33 had an open area to his sacral area. There were no measurements documented or description of the appearance of the open area.</td>
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<td>A Skin Integrity Report for Resident #33 was initiated on 1/28/19 to his sacrum. The report documented the appearance was 100% epithelial (ex. stg 2), measured 2.0 cm x 3.0 cm, and with minimal serous drainage.</td>
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<td>A physician's order, dated 3/15/19, documented the licensed staff were to cleanse the coccyx with wound cleanser, pat dry, apply anti-microbial gel (debridement to infected tissue), and cover with a dry dressing every day.</td>
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<td>On 3/26/19 at 3:33 PM, RN #2 was observed providing wound care to Resident #33's sacrum. RN #2 stated the wound bed measured 4.0 x 2.5 cm and was covered with slough. RN #2 stated the sacrum wound was unstageable due to the slough in the wound and worsened in size and description.</td>
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<td>c. An SBAR, dated 3/18/19, documented redness to Resident #33's left inner knee with measurements of 0.5 cm x 0.5 cm.</td>
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<td>On 3/25/19 at 3:40 PM, RN #1 stated Resident #33 developed a pressure ulcer to his left inner knee with measurements of 0.5 cm x 0.5 cm.</td>
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knee caused by putting pressure on his right inner knee. CNA #4 was observed applying a pillow between Resident #33’s knees. CNA #4 stated after Resident #33 developed the pressure ulcer he had been applying a pillow between his knees.

A physician’s order, dated 3/25/19, documented cleanse left inner knee with wound cleanser, pat dry, apply silvasorb (antimicrobial gel) to the wound bed, apply skin prep to peri-wound, and cover with a dry dressing every 3 days for an unstageable pressure ulcer.

A Nurse’s Progress Note, dated 3/26/19 at 6:53 PM, documented Resident #33 had a 3.0 cm x 2.0 cm open area with black coloring to 75% of the wound bed/edges.

Resident #33’s care plan did not include licensed staff were to place a pillow between his knees.

On 3/27/19 at 1:42 PM, RN #2 stated Resident #33 developed the unstageable pressure ulcer to his left knee was caused by the Sage boots being “poofy”, which positioned his knees together and that added more pressure.

On 3/28/19 at 10:06 AM, the DON stated Resident #33’s care plan did not include nursing staff were to place a pillow between his knees to prevent further breakdown.

2. Resident #7 was admitted to the facility on 10/15/18, with multiple diagnoses including breast cancer and hospice services.

Resident #7’s admission MDS assessment,
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| F 686 | Continued From page 55 dated 10/22/18, documented she was cognitively intact and at risk for pressure ulcers. Resident #7's care plan, dated 10/15/18, documented she was at risk for skin breakdown. Interventions in the care plan directed staff to assist with repositioning every two hours, observe skin condition with ADL care daily and report abnormalities, provide redistribution surfaces to chair and bed as per protocol, provide peri care/incontinence care as needed, float her heels while in bed with pillows, and complete weekly skin assessments by licensed nurse.

ADL flowsheets for February 2019 documented Resident #7 was to be turned and repositioned every two hours as specified in her plan of care. There was no documentation Resident #7 was turned and repositioned for all shifts on 2/1/19, and for the day shift on 2/12/19. On 2/9/19, 2/18/19, and 2/27/19, for the day shift staff documented it was "not applicable." On 2/13/19 and 2/14/19, for the evening shift staff documented it was "not applicable."

Resident #7's record included documentation of weekly skin checks. The weekly skin checks dated 2/1/19, 2/4/19, 2/11/19, 2/18/19, and 2/25/19, documented Resident #7 had no skin issues.

The skin check, dated 3/4/19, documented there were no skin issues for Resident #7. On 3/6/19, two days later, the skin check documented she had a Stage II pressure ulcer on her coccyx (tailbone). According to the Johns Hopkins Medicine website, accessed 4/17/19, a Stage II | F 686 | | | | | | | |
**F 686**
Continued From page 56

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<td>pressure ulcer is partial thickness loss of skin which presents as a shallow open area with a red/pink wound bed, and may also present as an intact or open/ruptured fluid filled blister.</td>
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An Incident and Accident Report, dated 3/6/19 at 10:00 AM, documented Resident #7 had developed a new in-house acquired Stage II pressure ulcer to the coccyx.

A physician assessment, dated 3/6/19, documented Resident #7 developed a pressure injury to the right buttock as a result of immobility and reduced nutrition.

Resident #7's TAR for March 2019 included a physician order, dated 3/6/19, for Z-guard (a skin protectant paste) to coccyx each day and night, and to discontinue when resolved. The Z-guard was not applied during the day shift on 3/9/19, 3/11/19, 3/19/19, 3/24/19, and 3/25/19. The Z-guard was not applied during the night shift on 3/12/19 and 3/18/19.

An SBAR Communication Form, dated 3/6/19, documented Resident #7 had a 0.3 cm x 0.3 cm open area which was non-blanchable and surrounded by blanching redness 7.5 cm x 4 cm x 0.2 cm entire area. The SBAR documented there was no drainage, the wound was intact, and no odor. The SBAR documented licensed staff were to apply a Z-guard twice daily and as needed until the wound resolved, and to notify the physician if it worsened.

A skin integrity report, dated 3/6/19, documented Resident #7 had a Stage II pressure ulcer to her coccyx, which measured 0.3 cm x 0.3 cm and...
continued From page 57

surrounded by non-blanching redness, 7.5 cm x 4 cm x 0.2 cm.

On 3/25/19 at 2:52 PM, Resident #7 was observed sitting in her bed and she stated everything was fine and she was happy with her care. She stated she was well taken care of and had no concerns or issues with the care provided by the facility. Resident #7 stated the facility was taking care of her pressure ulcer.

On 3/25/18 at 3:30 PM, RN #2, who was the wound nurse, stated she completed weekly skin checks, changed dressings and provided wound care on her assessments, which included wound measurements. RN #2 stated the nurses provided daily wound care.

On 3/28/19 at 9:15 AM, RN #2 reviewed Resident #7's record and stated she completed a skin check assessment on Resident #7 on 3/4/19, and found no skin issues. RN #2 stated the hospice CNA found the pressure ulcer on her coccyx and reported it to her and the hospice nurse. RN #2 stated she assessed the wound and the hospice nurse assessed the wound. RN #2 stated she thought the pressure ulcer developed due to Resident #7 declining in health, not expressing her needs to staff, staff not recognizing the change in condition she had experienced during this time, and due to Resident #7 indicating her care was “great." RN #2 stated Resident #7 did not request additional care and did not like to ask for help.

On 3/28/19 at 11:20 AM, RN #2 stated the care plan did not get updated with the interventions for wound care for the pressure ulcer identified on
F 686 Continued From page 58
3/6/19. RN #2 stated the nurses should have been updating the care plans. RN #2 stated the facility was going to provide Resident #7 a pressure hybrid bed, and the bed was not ordered, care planned or put in place. RN #2 stated the facility had the bed in-house and did not know why the bed placement was not initiated. RN #2 stated she had additional wound care notes separate from the TAR. RN #2 stated she kept separate notes to make sure the TAR was readily available to staff. The additional notes were not provided for review. RN #2 stated Resident #7's pressure ulcer had improved.

F 689 SS=D
Free of Accident Hazards/Supervision/Devices

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§483.25(d) Accidents.
The facility must ensure that -
§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and
§483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents.

This REQUIREMENT is not met as evidenced by:
- Based on observation, policy review, record review, and family and staff interview, it was determined the facility failed to provide adequate supervision to meet residents’ needs and implement fall interventions. This was true for 1 of 2 residents (#35) reviewed for supervision and falls. This created the potential for harm if residents experienced falls and injuries. Findings include:
  - The facility’s Falls Management policy, dated 3/15/16, directed staff to assess residents for risk

Resident #35 will be re-evaluated by the Center Nurse Executive or designee on or before 5/21/19 for fall risk, interventions to prevent falls including level supervision required. Follow-up will be completed as indicated by the review.
### SUMMARY STATEMENT OF DEFICIENCIES

**F 689 Continued From page 59**

Residents determined to be at risk for falls were to receive appropriate interventions to reduce the risk, minimize injury and actual occurrence of falls. Residents experiencing a fall were to receive appropriate care and an investigation of the cause of the fall was to be completed.

The facility's Falls Care Delivery Process, dated 7/25/16, directed staff to complete a nursing assessment and fall risk evaluation, manage the problem and monitor the outcomes on admission, quarterly, annually and with any significant change in condition. The purpose of the process was to identify the problem, cause and risk of falls. The fall response protocol directed staff to evaluate, monitor the resident, document and investigate circumstances, communicate and immediately intervene for the first 24 hours. The staff were to update the resident's care plan between 1-7 days and monitor the resident's response for 1-6 months.

These policy and procedures were not followed. Examples include:

- Resident #35 was admitted to the facility on 2/16/19, following surgical repair of a right upper femur (thigh bone) fracture, resulting from a fall. Resident #35's 2/16/19 Admission Record also documented she had difficulty walking, muscle wasting and atrophy, anxiety, and Alzheimer's disease. Resident #35 began hospice care on 3/12/19.

- Resident #35's admission MDS assessment, dated 2/23/19, documented her cognition was

**F 689 Identification of Other Residents**

A review of residents at risk for falls will be completed by the Center Nurse Executive or designee on or before 5/21/19 to ensure that fall plans including supervision required are included in the plan of care with interventions implemented at bedside.

**Systemic Changes**

Beginning 5/6/19, the Center Interdisciplinary team will review residents who fall in the morning clinical meeting to ensure falls are adequately investigated for root cause and to ensure that care plan interventions are implemented at bedside.

The Center Interdisciplinary Team and nursing staff will be re-educated on or before 5/21/19 by the Center Nurse Executive or designee on the fall management program that includes identification of fall risk factors, interventions to prevent falls, fall investigations, and root cause analysis.

**Monitoring**

Beginning the week of 5/22/19, an audit of five residents at risk for falls will be reviewed by the Center Nurse Executive or designee to ensure that there is a plan to prevent falls in place that is based on resident assessment. Beginning the week
### F 689

Continued From page 60

Severely impaired, she required one to two-person assist with ADLs, and was at risk for falls.

Resident #35's Falls Risk Assessments, dated 2/16/19, 2/20/19 and 3/15/19 documented she was at risk for falls. Resident #35's Falls Risk Assessment, dated 2/20/19, documented she had a fall in the last month prior to admission. Resident #35's Falls Risk Assessment, dated 3/15/19, documented she had two or more falls since admission.

Resident #35 was not provided the supervision necessary to protect her from falls, as follows:

*An Incident Report, dated 2/21/19, documented Resident #35 was found lying on the floor in her room at 10:30 AM, and had no injury. New interventions were to initiate 15-minute checks.

Resident #35's care plan, dated 2/27/19, directed staff to make sure her glasses were within reach and to encourage her to use them, and evaluate medication as needed.

Resident #35's Frequent Checks Report, dated 2/21/19 at 4:00 PM through 2/22/19 at 6:00 AM, documented she was checked by staff every 15 minutes. Resident #35's Frequent Checks Report, dated 2/22/19 at 7:15 AM through 2/25/19 at 7:00 AM, documented she was checked by staff every 15 minutes. Resident #35's Frequent Checks Report, dated 2/25/19 at 2:00 PM through 2/26/19 at 6:00 AM, documented she was checked by staff every 15 minutes. Resident #35's Frequent Checks Report, dated 2/27/19 at 7:15 AM through 5/22/19, an audit of five residents who fall will be reviewed by the Center Nurse Executive or designee to ensure that falls are investigated for root cause with a plan in place. These audits will be completed weekly x 4 weeks and then monthly x 2 months. The results of these audits will be compiled and reported to the QAPI committee for review and remedial intervention for three months. 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

5/21/19
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<td>2/29/19 at 7:00 AM, documented she was checked by staff every 15 minutes.</td>
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*An Incident Report, dated 3/8/19, documented Resident #35 was found lying on her back in her room at 7:45 AM, and had no injury. New interventions documented on the Incident Report were to check Resident #35's vital signs and complete neurological checks.

Resident #35's progress notes, dated 3/8/19, documented she was sent to the hospital for evaluation due to reports of pain, and returned from the hospital at 3:00 PM with an air splint to her left ankle. No fractures were found. Resident #35 was confused and had been moved to a room closer to the nurses' station.

*An Incident Report, dated 3/8/19, documented Resident #35 was observed in the hallway of 100 hall near the television room, where she tried to stand up from her wheelchair with both hands holding the wall handles and slid to the floor at 7:30 PM, and had no injury. New interventions were to initiate 30-minute checks while Resident #35 was awake. Resident #35's Frequent Checks Report, dated 3/8/18, did not document frequent checks.

Resident #35's care plan, dated 3/9/19, directed staff to initiate 30-minute checks while she was awake.

Resident #35's Frequent Checks Report, dated 3/9/19 at 7:30 AM through 3/10/19 at 7:00 AM, documented she was checked by staff every 30 minutes.
**F 689 Continued From page 62**

*An Incident Report, dated 3/11/19, documented Resident #35 was found on the floor in the front lobby, and tried to transfer to the couch from her wheelchair at 6:00 PM. New interventions were to assess Resident #35, administer anti-anxiety medication, and initiate frequent checks.

Resident #35's care plan, dated 3/11/19, directed staff to monitor her and assist her with her toileting needs on wakening, before and after meals and at night, and to provide cares during the night shift.

*Resident #35's Incident Report, dated 3/11/19, documented she was witnessed in the front lobby, and tried to transfer to the couch from her wheelchair at 6:10 PM. No new interventions were initiated.

Resident #35's progress notes, dated 3/11/19 at 7:35 PM, documented she had a fall, and vital signs were initiated. Resident #35's progress notes, dated 3/12/19, documented she was alert and confused, and was very active and ambulating the halls in her wheelchair, received anti-anxiety medication, and was monitored for falls.

Resident #35 Frequent Checks Report, dated 3/11/19 at 10:00 PM through 3/12/19 at 6:00 AM, documented she was checked by staff every 15 minutes.

*An Incident Report, dated 3/13/19, documented Resident #35 was found on the floor in the front lobby, and tried to transfer to the couch from her wheelchair at 2:00 PM. No new interventions were initiated. Resident #35's Frequent Checks
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Report, dated 3/13/19, did not document 15 - 30 minute checks.

Resident #35's care plan, dated 3/13/19, did not document additional interventions.

Resident #25's Frequent Checks Report, dated 3/14/19 at 7:15 AM through 3/20/19 at 7:00 AM, documented she was checked by staff every 15 minutes. Resident #35's Frequent Checks Report, dated 3/22/19 at 7:30 AM through 2:30 PM, documented she was checked by staff every 30 minutes, at 3:45 PM through 5:45 PM, documented she was checked by staff every hour, and at 6:15 PM through 3/23/19 at 5:45 AM, documented she was checked by staff every 15 minutes, and at 6:00 AM through 7:00 AM, documented she was checked by staff every 30 minutes. Resident #35's Frequent Checks Report, dated 3/25/19 at 7:30 AM through 3/26/19 at 7:00 AM, documented she was checked by staff every 30 minutes.

On 3/26/19 at 9:34 AM, Resident #35's family member stated by phone, the facility could have done a better job to prevent falls.

On 3/29/19 at 9:50 AM, the DON stated interventions were initiated after each fall from 2/21/19 through 3/13/19 and completed by the CNAs and nursing staff and were documented as a task to be complete and included in Resident #35's care plan. After review of the record, the DON stated the tasks and care plan were incomplete.

On 3/29/19 at 4:55 PM, the DON stated Resident #35 was checked every 15 - 30 minutes.
## Statement of Deficiencies and Plan of Correction

**Twin Falls Center**

**674 Eastland Drive**

**Twin Falls, ID 83301**

**Provider Identification Number:** 135104

**Survey Completed Date:** 04/01/2019

### Summary Statement of Deficiencies

**F689** Continued From page 64

Sporadically, based on the behaviors she presented. The DON stated the checks had been initiated on 3/29/19 after review showed the checks were not being completed. The DON reviewed and stated frequent checks were not being done on 3/8/19 and 3/13/19, and not completed consistently from 2/21/19 through 3/29/19.

The facility failed to provide supervision necessary to protect Resident #35 from falls, ensure her care plan was implemented, and revise her care plan when interventions did not prevent further falls.

**F697**

Pain Management

CFR(s): 483.25(k)

§483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.

This REQUIREMENT is not met as evidenced by:

- Based on observation, staff interview, policy review, and record review, it was determined the facility failed to ensure residents' pain levels were assessed and treated prior to wound care. This was true for 1 of 3 residents (Resident #33) reviewed for pain management. Resident #33 was harmed when he experienced increased pain during a dressing change and the facility did not identify and treat it. Findings include:

  - The facility's Pain Management policy, dated 3/1/18, documented nursing staff to maintain the

**Specific Residents Identified**

Resident #33 was discharged on 4/10/19.

**Identification of Other Residents**

Other resident's pain management regimen will be reviewed and residents will be evaluated for pain by the Center Nurse Executive or designee on or before
**Summary Statement of Deficiencies**

(F697 Continued From page 65)

- Highest possible level of comfort for patients by providing a system to identify, assess, treat, and evaluate pain. An individualized care plan will be developed and address and treat underlying causes of pain and using specific strategies for preventing or minimizing different levels or sources of pain or pain related symptoms.

- Resident #33 was admitted to the facility on 4/23/1996, with multiple diagnoses including a stroke with hemiplegia and hemiparesis (paralysis and weakness to one side of the body) affecting his right side.

- Resident #33's skin breakdown care plan, dated 10/29/18, documented licensed staff were to monitor for verbal and nonverbal signs of pain related to wound or wound treatment and medicate him as ordered.

- A physician’s order, dated 2/21/19, documented Resident #33 received a Fentanyl patch 12 mcg/hr apply 1 patch every 3 days; Tylenol 325 mg two tablets every 4 hours as needed for mild pain; and Norco 5/325 mg 1 or 2 tablets every 6 hours as needed for moderate or severe pain.

- On 3/25/18 at 3:30 PM, RN #1 was observed providing wound care to Resident #33's open area to his left heel. Resident #33 hollered out in pain and was flinching his left leg in pain during the removal of the dressing. RN #1 was attempting to remove the dried dressing by tugging on the dressing while it was stuck to the open wound. RN #1 stated to Resident #33 she would provide a pain pill after the wound care was completed. RN #1 stated she administered pain medication prior to the wound care. RN #1 5/21/19 and follow-up will be completed based on the assessment.

- A review of resident care plans/ Kardex will be completed by the Center Nurse Executive or designee on or before 5/21/19 to ensure that they reflect resident pain risk with treatment, individualized goals for pain management, and pain interventions/ approaches based on resident assessment. Updates to the care plan/Kardex will be completed as indicated by the review.

- **Systemic Changes**

  - Nursing staff will be re-educated on pain symptoms, assessment, interventions (pharmacologic and non-pharmacologic) by the Center Nurse Executive or designee on or before 5/21/19.

  - Beginning 5/6/19, residents with new orders for pain medication interventions will be reviewed in morning clinical meeting by the Center Nurse Executive or designee to ensure that orders for medication administration are clear and that pain evaluation orders are in place.

  - Beginning 5/6/19, residents reviewed during weekly Clinical at Risk meeting will be evaluated by the nursing representative related to pain management. Follow-up will be...
Resident #33 was harmed when the facility failed to administer pain medication prior to a dressing change or stop the dressing change when he hollered out in pain.

F 697 Continued From page 66
continued to remove the dried dressing without success, while Resident #33 was hollering and flinching his left leg in pain and she did not stop the procedure to relieve the pain.

Resident #33’s March 2018 MAR, documented Resident #33 received a Fentanyl patch of 12 mcg/hr on 3/23/19 and it was due to be changed on 3/26/19. Resident #33’s MAR did not include documentation he received the as needed Tylenol or Norco on 3/25/19.

Resident #33’s Narcotic Count Sheet for Norco 5/325 mg did not include documentation Resident #33 received Norco as needed pain medication on 3/25/19.

On 3/26/19 at 3:20 PM, RN #2 stated Resident #33 should receive pain medication 30 to 45 minutes prior to the dressing change.

On 3/28/19 at 9:09 AM, the DON stated there was no documentation in Resident #33’s record that he received as need pain medication on 3/25/19. The DON stated RN #1 should have administered pain medication prior to the dressing change and should have stopped when he was hollering out in pain.

Resident #33 was harmed when the facility failed to administer pain medication prior to a dressing change or stop the dressing change when he hollered out in pain.

F 732 SS=C
Posted Nurse Staffing Information
CFR(s): 483.35(g)(1)-(4)
§483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility

F 697 completed as indicated.

Monitoring
Beginning the week of 5/22/19, 5 residents will be reviewed by the Center Nurse Executive or designee for pain management program components. These audits will be completed weekly X 4 weeks and then monthly x 2 months. The results of these audits will be reported to the center QAPI committee for review and remedial intervention monthly X3 months. The Center Nurse Executive is responsible for monitoring and follow-up.

Date of Compliance
5/21/19
<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
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<tr>
<td>F 732</td>
<td>Continued From page 67 must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to post the actual nursing F 732</td>
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<td>F 732</td>
<td>Continued From page 68</td>
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F 732
hours being provided and failed to post the staffing information in a prominent and visible location for all residents, resident representatives, and visitors to see. Findings include:

On 3/25/19 at 1:30 PM, 3/26/19 at 8:30 AM, and 3/27/19 at 9:03 AM, the daily nurse staffing information was not found in the facility.

On 3/27/19 at 9:18 AM, the DON stated the daily nurse staffing was posted on the wall across from the nurse's station. The DON showed the surveyor a daily assignment sheet for what halls the nursing staff were assigned to. The DON questioned if this was what the surveyor was looking for. The DON flipped the daily assignment sheet with showing the scheduled hours specific nursing staff was stapled behind the daily assignment sheet.

On 3/27/19 at 9:20 AM, the facility's nursing scheduler stated the Administrator posted the daily nurse staffing information.

On 3/27/19 at 9:23 AM, the Administrator stated the daily assignment sheet was not the daily nurse staffing information being posted daily.

F 732
Specific Residents Identified and Identification of Other Residents

Starting on 3/31/19, the actual daily nurse staffing hours will be posted by the Facility Nursing Staffing Coordinator or designee in a prominent and visible location for all residents, resident representatives and visitors to see each day.

Systemic Changes

Facility Nursing Staffing Coordinator will be educated on or before 5/21/19 by the Center Executive Director on the requirement that the actual daily nurse staffing hours be posted in a prominent and visible location for all residents, resident representatives and visitors to see each day.

Monitoring

Beginning on 5/22/19, posting of the daily nurse staffing hours will be verified by the Center Executive Director or designee each day. Audit reports will be completed daily for 12 weeks by the Center Executive Director or designee to ensure that the hours are posted as required. Audit reports will be reviewed by the QAPI Committee monthly for 3 months for review and remedial intervention. The Center Executive Director is responsible.
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<th>ID PREFIX</th>
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<tr>
<td>F 732</td>
<td></td>
<td>Continued From page 69 for monitoring and compliance. The QAPI Committee will re-evaluate the need for further monitoring after 3 months.</td>
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<tr>
<td>F 758</td>
<td>SS=D</td>
<td>Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5)</td>
<td>F 758</td>
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<td>5/21/19</td>
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§483.45(e) Psychotropic Drugs.
§483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:

(i) Anti-psychotic;
(ii) Anti-depressant;
(iii) Anti-anxiety; and
(iv) Hypnotic

Based on a comprehensive assessment of a resident, the facility must ensure that---

§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...
**SUMMARY STATEMENT OF DEFICIENCIES**

Each deficiency must be preceded by full regulatory or LSC identifying information.

<table>
<thead>
<tr>
<th>ID</th>
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<tr>
<td>F758</td>
<td>Continued From page 70</td>
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<td>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</td>
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<td>§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.</td>
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<td>§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 policy review, record review, and staff interview, it was determined the facility failed to ensure residents receiving psychotropic medications had resident-specific behaviors identified and monitored related to use of the medications, and orders for as needed (PRN) psychotropic medications did not exceed 14 days without clear rationale from the physician. This was true for 2 of 6 residents (#27 and #35) reviewed for unnecessary medications. This failure created the potential for harm if residents receive psychotropic medications that were unwarranted, ineffective, and used for excessive duration. Findings include: The facility’s Psychotropic Medication Use policy and procedure, dated 11/28/16, directed staff to</td>
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<td>On or before 5/21/19, Residents #27 and #35 will be assessed by the Center Nurse Executive or designee for adverse effects related to receiving unnecessary medications.</td>
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<td>On or before 5/21/19 the Center Nurse Executive or designee will review the psychotropic medications that resident #27 receives and her behaviors to determine if there is a medical, physical, functional, social, psychological or</td>
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</table>
F 758 Continued From page 71

limit PRN orders for psychotropic drugs to 14 days. If the attending physician believed that it was appropriate for the PRN order to be extended beyond 14 days, they should document their rationale in the resident's medical record and indicate the duration for the PRN order and should not be renewed unless the resident was evaluated for appropriateness of that medication.

The policy directed staff to not use psychotropic medications to address behaviors without first determining if there was a medical, physical, functional, psychological, social or environmental cause of the resident's behaviors. The policy directed staff to monitor behavioral triggers, episodes, and symptoms, and document the number and/or intensity of symptoms and the resident's response to staff interventions.

1. Resident #35 was admitted to the facility on 2/16/19, with multiple diagnoses including dementia, anxiety, and Alzheimer's disease. Resident #35 began hospice care on 3/12/19.

Resident #35's admission MDS assessment, dated 2/23/19, documented her cognition was severely impaired, and received psychotropic medications.

a. Resident #35's physician orders, dated 3/11/19, documented she was prescribed Lorazepam Tablet 0.5 mg one by mouth every six hours as needed for situational anxiety for 90 days, and the end date 6/9/19. Resident #35's record did not include the physician's rationale for use of the as needed Lorazepam beyond 14 days.

F 758 environmental cause of the resident behaviors. The physician will be contacted as indicated and the resident medications, behavior sheets and care plans will be updated by the Center Nurse Executive on or before 5/21/19 to accurately reflect the resident's current needs for residents #27.

The Lorazepam and Mirtazapine were discontinued for resident #35 on 4/2/19.

Identification of Other Residents

On or before 5/21/19, the Center Nurse Executive or designee will review resident psychotropic medications, behavior sheets and care plans for accuracy. Resident care plans that have identified discrepancies will be revised to reflect the resident's current status and follow up completed by the Center Nurse Executive or designee to reflect resident current status, medications, behaviors and services provided.

Systemic Changes

On or before 5/21/19, the Center Nurse Executive or designee will educate facility licensed nurses and the interdisciplinary team regarding the facility policy for timely and accurate care plan revisions, the facility psychotropic medication use policy including behavior monitoring and documenting behaviors or no behaviors.
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:** 135104

**DATE SURVEY COMPLETED:** 04/01/2019

**NAME OF PROVIDER OR SUPPLIER**

**TWIN FALLS CENTER**

<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
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<th>PROVIDER'S PLAN OF CORRECTION</th>
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<tr>
<td>F 758 Continued From page 72</td>
<td>On 3/29/19 at 4:10 PM, the DON stated there should have been a physician's rationale for the use of Lorazepam to be used beyond 14 days. b. Resident #35's physician orders, dated 2/16/19 and 3/11/19, documented she was prescribed Mirtazapine (antidepressant also used to treat anxiety) tablet one by mouth at bedtime for dementia. Resident #35's care plan, dated 2/22/19 and updated 2/24/19 and 3/21/19, documented she had impaired/decline in cognitive function or thought process related to Alzheimer's disease and dementia, and was at risk for complications related to the use of psychotropic drugs. Interventions included in the care plan directed staff to monitor and evaluate her for mental status and functional level and to report to the physician when indicated. The care plan interventions also directed staff to monitor Resident #35 for wandering, psychiatric disorder, cognitive loss/dementia, delirium, delusions, and hallucinations. Resident #35's care plan care plan did not describe resident-specific behaviors related to anxiety staff were to monitor for the use of the Lorazepam or specific symptoms of dementia to monitor for the use of the Mirtazapine. On 3/28/19 at 3:03 PM, the DON, with the Clinical Quality Specialist present, reviewed Resident #35's care plan and stated the care plan was initiated by the nurse and should have directed staff to monitor for her specific resident-focused behaviors. On 3/29/19 at 4:10 PM, the DON, with the</td>
<td>F 758 on each shift</td>
<td>Beginning 5/6/19, residents will be reviewed by the Center Nurse Executive or designee in daily clinical meeting to ensure resident changes of condition including behaviors and medication changes are reflected accurately on the care plan and behavior sheets. Beginning 5/6/19, new admissions charts will be reviewed at daily clinical meeting to ensure behaviors and medications are reviewed and care plans accurately reflect the patient's condition. Follow up will be completed as indicated. Monitoring Beginning the week of 5/22/19, audits of 5 resident care plans and behavior sheets will be reviewed by the Center Nurse Executive or designee to ensure that residents' care plans have been updated to accurately reflect the resident's current status including behaviors and interventions and that documentation of behaviors or no behaviors is occurring on each shift. Follow up for identified residents will be completed as indicated. Audits will be completed weekly x 4 weeks, then monthly x 2 months. 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</td>
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<td>(X5) COMPLETION DATE</td>
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FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: MVIT11 Facility ID: MDS001800 If continuation sheet Page 73 of 86
### Statement of Deficiencies and Plan of Correction

**Twin Falls Center**

**Address:** 674 Eastland Drive, Twin Falls, ID 83301

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

**Date Survey Completed:** 04/01/2019

### Summary Statement of Deficiencies

#### F 758 Continued From page 73

Clinical Quality Specialist present, stated Resident #35 did not have a diagnosis of depression. The DON stated Mirtazapine order was documented on 2/16/19 by the Case Manager for a diagnosis of dementia, and should have been documented for use of an appetite stimulant. The DON stated the original Mirtazapine order came from the hospital and should have been reviewed at the time of admission.

c. Resident #35's behavior monitoring and intervention forms, documented by exception the behaviors of anxiety, restlessness, agitation/anger, anger, and refusals of care. Resident #35 had one documented episode of agitation/anger on 3/15/19. Resident #35's behaviors were not monitored daily to ensure accurate data collection.

On 3/28/19 at 2:45 PM, the LPN #3 stated the resident behaviors were documented on the behavior monitoring and intervention forms by exception only.

On 3/29/19 at 8:46 AM, the LSW stated resident behaviors were documented only by exception.

2. Resident #27 was admitted to the facility on 9/7/18, with multiple diagnoses including congestive heart failure, aphasia (an impairment of language due to brain injury, affecting the production or comprehension of speech and the ability to read or write), cerebral infarction (stroke), dementia, depression, bipolar disorder, and Parkinson's Disease.

Resident #27's quarterly MDS assessment, dated

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<td>F 758</td>
<td>Committee will re-evaluate the need for further monitoring after 3 months.</td>
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<td>Date of Compliance</td>
<td>5/21/19</td>
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<tr>
<td>ID PREFIX</td>
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<td>SUMMARY STATEMENT OF DEFICIENCIES</td>
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| F 758     |     | Continued From page 74  
1/17/19, documented her cognition was severely impaired and she received psychotropic medications.  
Resident #27’s physician orders, dated 9/7/18, documented she was prescribed Celexa (antidepressant) tablet 20 mg given by mouth one time a day for depression and Aricept (to treat dementia) tablet 10 mg given one by mouth at bedtime for dementia/hallucinations.  
   a. Resident #27’s care plan revised on 4/28/18, 10/29/18, and 2/24/19, documented she was at risk for distress and fluctuating mood symptoms related to depression and sadness and was at risk for complications related to the use of psychotropic drugs. Interventions included in the care plan directed staff to monitor Resident #27 for signs and symptoms of worsening sadness and depression, extreme mood swings, impulsive behavior, and paranoia, and to monitor her behaviors. Resident #27’s care plan documented she had a history of hallucinations. Interventions included in the care plan directed staff to watch for hallucinating indicators and report them to nursing and/or social services. Resident #27’s care plan did not describe her specific signs and symptoms of depression to monitor for the use of Celexa and her resident-specific behaviors to monitor for the use of the Aricept.  
On 3/28/19 at 3:03 PM, the DON, with the Clinical Quality Specialist present, reviewed Resident #27’s care plan and stated the care plan was initiated by the nurse and should have directed staff to monitor for her specific resident-focused behaviors. | F 758 | | |
### SUMMARY STATEMENT OF DEFICIENCIES

**F 758**
Continued From page 75

b. Resident #27’s behavior monitoring and intervention forms, documented sad affect, tearfulness, decreased motivation, agitation, anger, withdrawn, and anxiety, related to depression, and mood swings, related to bipolar disorder, by exception only. Resident #27’s behaviors were not monitored daily to ensure accurate data collection.

On 3/28/19 at 3:03 PM, the DON, with the Clinical Quality Specialist present, reviewed Resident #27’s care plan and stated the care plan was initiated by the nurse and should have directed staff to monitor for her specific resident-focused behaviors.

**F 761**
Label/Store Drugs and Biologicals

<table>
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<th>CFR(s): 483.45(g)(h)(1)(2)</th>
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§483.45(g) Labeling of Drugs and Biologicals

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.

§483.45(h) Storage of Drugs and Biologicals

§483.45(h)(1) 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.

§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug...
<table>
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<th>F 761</th>
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<td>Abuses Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, policy review, record review, and staff interview, it was determined the facility failed to ensure expired medications were not available for administration, expired biological supplies were removed for resident use, and biological supplies were labeled prior to use. This was true for 2 of 4 medication carts, 1 of 1 medication storage rooms, and 1 of 3 refrigerators reviewed for safe storage and labeling medication. This failure created the potential for harm to all residents in the facility should residents receive medications with decreased efficacy, potency and safety. Findings include: The facility's Storage and Expiration Dating of Medications, Biologicals, Syringes and Needles policy and procedure, dated 10/31/16, directed staff to ensure medications and biologicals that have an expired date on the label and have been retained longer than recommended by manufacturer or supplier guidelines, are stored separate from other medications until destroyed or returned to the pharmacy or supplier. Once any medication or biological package was opened, the facility staff should follow the manufacturer/supplier guidelines with respect to expiration dates for opened medications and record the date opened on the medication container when the medication had a shortened expiration date once opened. The policy further</td>
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<td>Specific Residents Identified and Identification of Other Residents</td>
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<td>The expired medications and expired biological supplies found in the 400 hall medication cart, the 100/200 hall medication cart, the medication room refrigerator and the medication supply room were removed and destroyed by the Center Nurse Executive or designee on 3/27/19. Other medication carts and biological storage areas in the facility were inspected by the Center Nurse Executive or designee on or before 5/21/19 and any expired medications or expired biological supplies were removed and destroyed. Systemic Changes Facility nursing and central supply staff will be educated on or before 5/21/19 by the Center Nurse Executive or designee regarding the facility policy on Storage and expiration dating of Medications, Biologicals, Syringes and Needles. Beginning on 5/6/19, the Center Nurse Executive or designee will inspect facility</td>
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<td><strong>F 761</strong></td>
<td>Continued From page 77 directed, medications with a manufacture's expiration date expressed in month and year (e.g., May, 2019) will expire on the last day of the month.</td>
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<td>1. On 3/27/19 at 10:15 AM, Resident #9's nitroglycerine medicine observed in the 400 Hall medication cart expired on 1/18/19. At the same time, LPN #1 reviewed the expired medication and stated the nitroglycerine for Resident #9 had expired and needed to be discarded.</td>
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<td>2. On 3/27/19 at 10:45 AM, a mineral oil container observed in the medication cart on the 400 Hall expired on 1/2019. At the same time, LPN #1 reviewed the expired mineral oil and stated the expired mineral oil needed to be discarded.</td>
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<td>3. On 3/27/19 at 11:00 AM, a mineral oil container observed in the medication cart on the 201-208/101-105 Hall, expired on 1/2019. At the same time, the ICN reviewed the mineral oil and stated the expired mineral oil should be discarded along with the other mineral oil found expired in the 400 Hall medication cart. The ICN stated each month, pharmacy reviewed the medications, and central supply reviewed the supplies in the storage room for expired dates.</td>
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<td>4. On 3/27/19 at 10:30 AM, observation of the medication supply room, identified the following medication and supplies were expired:</td>
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<td>* Twenty-one insulin pens expired 8/2017</td>
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<td>* Three blue blood collection tubes expired on 1/31/19</td>
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**F 761** medication carts and medication storage room/refrigerators weekly to ensure that expired medications and expired biologicals are removed and destroyed.

**Monitoring**

Beginning on 5/22/19, weekly audits of the facility medication carts and the medication storage room/refrigerators will be completed by the Center Nurse Executive or designee for 12 weeks to ensure that expired medications and biological supplies are removed from the facility or destroyed according to the facility policy.

Audits will be reviewed by the QAPI Committee monthly for 3 months for review and remedial intervention. 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**

5/21/19
In refrigerator #3, a Tuberculin (serum used to test for tuberculosis) multi-use vial was dated as opened on 10-7-18.

On 3/27/19 at 10:30 AM, LPN #2, with the ICN present, reviewed the expired insulin pens and blood collection tubes, and stated they should have been discarded.

On 3/27/19 at 10:30 AM, the ICN stated the Tuberculin multi-use vial was opened on 10/7/18 and should have been should have been discarded after 28 days.

5. The AOB Annals of Blood Journal for High-Quality Research in Hematology website, dated February 2018, accessed on 4/19/18, documented The Clinical and Laboratory Standards Institute (CLSI)'s efforts to prevent mislabeling [of blood specimens] include:

- Requiring patients to state their full name and birth date, and to spell their first name and last name;
- Requiring outpatients to show a form of identification when an ID band is not in use, typically a driver's license or insurance card;
- Labeling specimen tubes in the presence of the patient after the draw;
- Visually comparing tube labels with the ID band or requiring the patient to confirm samples are properly labeled.

On 3/27/19 at 10:30 AM, two yellow chemistry blood collection tubes observed in the medication room were labeled with patient information prior to use. This did not follow professional standards of practice for labeling blood specimens.
## F 761 Continued From page 79

On 3/27/19 at 10:30 AM, LPN #2, with the ICN present, reviewed the labeled blood collection tube, and stated it should have been discarded.

On 3/27/19 at 1:07 PM, the Central Supply Director, with the ICN present, stated each month she checked all the over-the-counter medications and biological supplies such as bandages dressings, syringes, and CNA supplies, in the storage room for expired dates. The Central Supply Director said she documented the information and gave expired medications and supplies to the DON for disposal. The Central Supply Director also stated she reviewed items that need to be ordered, and each year provided an inventory for the corporate office. The ICN stated nurses reviewed the refrigerators and medication carts for expired medication. She said all other medications, including the medication in the Pyxis (automated medication dispensing system) were reviewed by Pharmacy. The Central Supply Director and ICN stated the blood collection tubes were supplied by the hospital.

## F 880 Infection Prevention & Control

**CFR(s):** 483.80(a)(1)(2)(4)(e)(f)

§483.80 Infection Control
The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention...
F 880 Continued From page 80

and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:

(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv) When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct
### 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 Prefix/Tag</th>
<th>Summary Statement of Deficiencies (Each Deficiency Must Be Preceded by Full Regulatory or LSC Identifying Information)</th>
<th>Provider's Plan of Correction (Each Corrective Action Should Be Cross-Referenced to the Appropriate Deficiency)</th>
<th>Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 880</td>
<td>Continued From page 81 contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.</td>
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<td>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</td>
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<td>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</td>
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<td>§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:</td>
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<td>Based on observation, staff interview, and policy review, it was determined the facility failed to ensure staff performed hand hygiene, and follow professional standards of practice for a clean dressing change. This was true for 1 of 11 residents (Resident #33) who were observed for infection control. This failure created the potential for harm by due contamination of a clean dressing and residents to the risk of infection and cross contamination. Findings include:</td>
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<td>The facility's Hand Hygiene policy, revised 11/28/17, included staff were to perform hand hygiene before patient care, before an aseptic (clean procedure to prevent contamination) procedure, after any contact with blood or other body fluids, (even if gloves are worn), after patient care, and after contact with the patient's environment.</td>
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<td>F880 Specific Residents Identified</td>
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<td>Resident #33 was discharged from the facility on 4/10/2019.</td>
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<td>Identification of other Residents</td>
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<td>On or before 5/21/19, the Center Nurse Executive or designee will conduct an audit of residents for signs and symptoms of infection. Residents identified to have signs or symptoms of infection will be</td>
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### SUMMARY STATEMENT OF DEFICIENCIES

<table>
<thead>
<tr>
<th>(X4) ID PREFIX TAG</th>
<th>(X5) COMPLETION DATE</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
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<tr>
<td>F 880</td>
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On 3/25/19 at 3:20 PM, an isolation station was observed outside Resident #33's room. There was no sign or direction of what precautions were to be taken.

On 3/25/19 at 3:25 PM, the following was observed:

* RN #1 put on a protective gown. RN #1 stated Resident #33 had MRSA (Methicillin-resistant Staphylococcus aureus, a bacterium with antibiotic resistance) in his left heel wound. RN #1 washed her hands and applied gloves to provide wound care to Resident #33's left heel. RN #1 removed the MRSA infected dressing from Resident #33's left heel. RN #1 did not remove her gloves or perform hand hygiene after she removed the infected dressing. She then handled the wound cleanser with her contaminated left gloved hand and sprayed the cleanser on clean 4 x 4 gauze dressings in her right hand. RN #1 then applied the contaminated clean dressings sprayed with wound cleanser to Resident #33's wound. She placed a dry 4 x 4 gauze over the sprayed gauze and secured the dressing by wrapping Resident #33's left heel with the dirty gloves. RN #1 removed her left glove to grab a sharpie pen out of her left pocket, then removed her right glove to write the date on Resident #33's dressing. RN #1 did not remove her gloves or perform hand hygiene after completing the dressing change. RN #1 did not disinfect the wound cleanser bottle after touching it with her dirty glove. RN #1 did not disinfect the sharpie pen before she put it back in her pocket. RN #1 obtained clean gloves to apply without first performing hand hygiene, then grabbed her hand sanitizer out of her pocket, rubbed her hands reported to the physician and findings will be addressed as indicated.

A center wide infection control round will be completed by the Center Nurse Executive or designee to identify any infection control concerns and to ensure appropriate signage is posted for transmission based precautions on or before 5/21/19. Corrective actions will be implemented at the time of the identified concern.

Direct care staff will be observed completing hand hygiene by the Center Nurse Executive or designee on or before 5/21/19 to ensure that hand hygiene was completed per policy/guidelines. Any discrepancies will be immediately addressed.

Licensed nurses will be observed completing an aseptic dressing change by the Center Nurse Executive or designee on or before 5/21/19. Any concerns related to infection control practices during wound care will be addressed at that time.

Systemic Changes
### Summary Statement of Deficiencies

<table>
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<tr>
<th>ID</th>
<th>PREFIX</th>
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<tr>
<td>F 880</td>
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<td>Continued From page 83</td>
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<td>On or before 5/21/19, the Center Nurse Executive or designee will provide education to staff regarding infection prevention measures including hand hygiene and signage for transmission based precautions.</td>
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<td>together, then applied the gloves she was holding. * CNA #4 removed Resident #33's soiled brief, performed peri-care, and put a clean brief on Resident #33. CNA #4 did not remove his gloves or perform hand hygiene. CNA #4 then started to remove Resident #33's wet shirt. CNA #4 was asked to stop and remove his gloves and to perform hand hygiene. On 3/27/19 at 9:44 AM, the Infection Control Nurse stated Resident #33 had MRSA in his wound and it was contained with the dressing. The Infection Control Nurse stated there used to be a sign up that directed all staff and visitors to check in with the nurse prior to entering Resident #33's room. The Infection Control Nurse stated everyone was putting on all the protection gear before entering his room, when they did not need to if they were not providing wound care to the infected area. The Infection Control Nurse stated she would place a sign up to direct staff and visitors when to apply the isolation precautions. The Infection Control Nurse stated RN #1 and CNA #4 should have removed their gloves and performed hand hygiene. RN #1 stated additional hand hygiene education would be provided. On 3/28/19 at 9:09 AM, the DON stated RN #1 and CNA #4 should have removed their gloves and performed hand hygiene.</td>
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<td>On or before 5/21/19, the Center Nurse Executive or designee will provide education to Licensed Nurses on infection prevention measures and aseptic technique during wound care/dressing changes. On or before 5/21/19, the Center Nurse Executive or designee will complete a hand-washing competency for staff who provide care to patients. On or before 5/21/19, the Center Nurse Executive or designee will complete an aseptic wound dressing change competency for Licensed Nurses who provide wound care or dressing changes. Beginning 5/6/19, residents/rooms that require transmission based precautions will be inspected weekly by the Center Nurse executive or designee to ensure signage is posted appropriately.</td>
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**Note:**
- **Deficiency F 880:** This deficiency was continued from page 83.
- The Center Nurse Executive or designee will provide education to staff regarding infection prevention measures including hand hygiene and signage for transmission based precautions.
- RN #1 and CNA #4 should have removed their gloves and performed hand hygiene.
- Monitoring.
### Statement of Deficiencies and Plan of Correction

**BEGINNING THE WEEK OF 5/22/19,** the Center Nurse Executive or designee will conduct a weekly audit of 5 staff members for hand hygiene per policy/guidelines.

Beginning the week of 5/22/19, the Center Nurse Executive or designee will conduct a weekly audit of 2 licensed nurses completing aseptic wound dressing changes to ensure aseptic technique is maintained.

Beginning the week of 5/22/19, the Center Nurse Executive or designee will conduct a weekly audit of 5 residents for need of transmission based precautions signage at room.

Audits will be completed weekly x4 weeks, then monthly x 2 months. 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 will re-evaluate the need for further monitoring after 3 months.

**Date of Compliance**

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TWIN FALLS CENTER

674 EASTLAND DRIVE
TWIN FALLS, ID 83301

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135104

(X2) MULTIPLE CONSTRUCTION
A. BUILDING _____________________________
B. WING _____________________________

(X3) DATE SURVEY COMPLETED 04/01/2019

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

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

FORM CMS-2567(02-99) Previous Versions Obsolete
Event ID: MVIT11
Facility ID: MDS001800
If continuation sheet Page 86 of 86
August 9, 2019

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

Provider #:  135104

Dear Ms. Bentzler:

On April 1, 2019, an unannounced on-site complaint survey was conducted at Twin Falls Center. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00008041

ALLEGATION #1:

Residents were not sent to the hospital when needed for evaluation and they were not provided a clean, homelike environment.

FINDINGS #1:

An unannounced complaint survey was conducted in conjunction with the annual recertification survey on 3/25/19 to 3/29/19. During the survey, observations were conducted, interviews were conducted with residents, family members and staff, resident records were reviewed, and facility grievances and Incident and Accident reports were reviewed.

The facility's grievance logs and Incident and Accident reports were reviewed, and no concerns related to the allegations were identified.
Six residents and two family members were interviewed and did not have concerns with care related to Activities of Daily Living (ADL). Care and concerns related to medications were addressed with the residents interviewed and/or their representatives, with no concerns identified. The residents and two family members had no complaints with ADLs, linens were changed, no soiled linens were observed on beds during the survey, and residents were dressed in clean clothes throughout the survey. The facility was clean, and no odors were present.

Sixteen resident records were reviewed and one record documented the resident had recently been discharged from the hospital and was on a blood thinner which required regular laboratory testing for therapeutic levels. The laboratory tests ordered by the physician were performed, and medication adjustments were made after the results were reviewed with the physician and consulting pharmacist. The resident was transferred back to the hospital by ambulance due to the family's request and not due to a medical emergency. The hospital was contacted and there were no laboratory results which documented the resident had an extremely low blood count and required multiple transfusions. The resident did not return to the facility.

Based on the investigation the allegations in the complaint could not be substantiated and no deficiencies were cited.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

As none of the allegations were substantiated, 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

LT/slj