



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

CERTIFIED MAIL: 7009 0820 0000 2798 6352

February 14, 2012

Joseph Reese, Interim Administrator
Idaho Falls Care & Rehabilitation Center
3111 Channing Way
Idaho Falls, ID 83404

Provider #: 135107

Dear Mr. Reese:

On **January 26, 2012**, a Recertification, Complaint Investigation and State Licensure survey was conducted at Idaho Falls Care & Rehabilitation Center by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be an isolated deficiency that constitutes actual harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies, and a similar State Form 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 in column X5 Complete Date, to signify when you allege that each tag will be back in compliance.**

After each deficiency has been answered and dated, the administrator should sign both the Form CMS-2567 and State Form in the spaces provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **February 27, 2012**. Failure to submit an acceptable PoC by **February 27, 2012**, may result in the imposition of civil monetary penalties by **March 18, 2012**.

The components of a Plan of Correction, as required by CMS include:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. This monitoring will be reviewed at the follow-up survey, as part of the process to verify that the facility has corrected the deficient practice. Monitoring must be documented and retained for the follow-up survey. In your Plan of Correction, please be sure to include:
 - a. Specify by job title who will do the monitoring. It is important that the individual doing the monitoring has the appropriate experience and qualifications for the task. The monitoring cannot be completed by the individual(s) whose work is under review.
 - b. Frequency of the monitoring; i.e., weekly x 4, then q 2 weeks x 4, then monthly x 3. A plan for 'random' audits will not be accepted. Initial audits must be more frequent than monthly to meet the requirement for the follow-up.
 - c. Start date of the audits;
- Include dates when corrective action will be completed in column 5.

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 both the federal survey report, Form CMS-2567 and the state licensure survey report, State Form.

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

This agency has notified CMS Region X of the results of this survey. If CMS decides to implement any remedies other than those listed below, CMS will notify the facility in a separate letter.

If substantial compliance has not been achieved by April 24, 2012, this agency must recommend denial of payment for new admissions effective **April 24, 2012**. [42 CFR §488.417(a)]

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **July 24, 2012**, if substantial compliance is not achieved by that time.

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

If you believe these deficiencies have been corrected, you may contact Loretta Todd, R.N. or Lorene Kayser, L.S.W., Q.M.R.P., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0036, Phone #: (208) 334-6626, Fax #: (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. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

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

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

- BFS Letters (06/30/11)

2001-10 Long Term Care Informal Dispute Resolution Process

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2001-10 IDR Request Form

This request must be received by **February 27, 2012**. If your request for informal dispute resolution is received after **February 27, 2012**, 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, please contact us at (208) 334-6626.

Sincerely,

A handwritten signature in cursive script that reads "Loretta Todd". The signature is written in black ink and is positioned above the printed name.

LORETTA TODD, R.N., Supervisor
Long Term Care

LT/dmj
Enclosures

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 135107	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 1/26/2012
NAME OF PROVIDER OR SUPPLIER IDAHO FALLS CARE & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3111 CHANNING WAY IDAHO FALLS, ID	
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		
F 514	<p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview it was determined the facility failed to ensure resident records were complete for 2 of 15 sample residents, (#2 and #14.) Resident #2's meal monitors were incomplete, and Resident #14's nurse's notes contained an undated, unsigned change of condition entry for a fall. Findings include:</p> <p>1. Resident #2 was admitted to the facility on 12/15/09 with diagnoses of dementia, Parkinson's disease, diabetes mellitus and kidney failure.</p> <p>The resident's Diabetes Care Plan, revised on 9/30/11, documented the resident as being at risk for Hyper/Hypoglycemia episodes related to Type II diabetes. An intervention to address the problem was "Diet as ordered. Monitor meal intake."</p> <p>Meal Intake documentation was reviewed form 9/11 - 12/11 and the following were noted:</p> <p>*10/11 - 11 meals and 6 HS (bedtime) snacks not documented. *12/11 - 3 meals and 10 HS snacks not documented.</p> <p>The Administrator and DON were informed of the findings on 1/25/12 at 4:30 p.m. No further information was provided by the facility.</p> <p>2. Resident #14 was admitted to the facility on 10/20/11 and readmitted on 1/24/12 with diagnoses of aftercare healing of traumatic fracture to bone, dementia, atrial fibrillation, chronic pulmonary and heart disease and depression.</p> <p>A "Change of Condition Documentation" form was present in the Interdisciplinary Progress Notes section of the resident record. The form entry described the resident falling to her knees when trying to ambulate to the bathroom. No date or signature of the staff making the entry were present on the form.</p> <p>The Administrator and DON were informed of the findings on 1/25/12 at 4:30 p.m. No further information was provided by the facility.</p>		

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

The above isolated deficiencies pose no actual harm to the residents

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F 514	Continued From Page 1		

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

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135107	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/26/2012
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F 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the annual recertification survey and complaint investigation of your facility.</p> <p>The surveyors conducting the survey were:</p> <p>Lea Stoltz, QMRP, Team Coordinator Arnold Rosling, RN Madeleine Parmley, RN</p> <p>Survey Definitions: MDS = Minimum Data Set assessment DON = Director of Nursing DNS = Director Nursing Service LN = Licensed Nurse CNA = Certified Nurse Aide ADL = Activities of Daily Living MAR = Medication Administration Record</p>	F 000	<p>"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Idaho Falls Care & Rehabilitation Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."</p> <p>F241</p> <p>1. Residents #1 was shaved, had their hair combed and his shirt changed by the CNA on 1/22/2012. Resident #8 was shaved, had their hair combed and his shirt changed by the CNA on 1/22/2012. Resident #1 was discharged from the center on 1/29/2012. Resident #8 was interviewed by the Social Services Director on 2/15/2012 related to dignity and respect. CNA #1 was provided re-education on or before 2/20/12 by the Director of Nursing Services/Designee related to asking if residents would like a clothing protector prior to application and the importance of respecting resident dignity and promoting resident choice.</p>	
F 241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on a complaint from the public, observation and family interview, it was determined that the facility failed to ensure residents were groomed prior to going to the dining hall for meals. This lack of grooming had the potential to affect the self esteem of the residents. This was true for 2 of 13 (#s 1 & 8) sampled residents. Findings include:</p>	F 241		

FACILITY STANDARDS
RECEIVED
MAR 22 2012

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE Administrator DATE 3-20-12

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

See attached addendum rec'd via email from administrator on 03/30/2012 @ 6:24 PM LK

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F 241	<p>Continued From page 1</p> <p>1. Resident #8 was admitted to the facility on 6/7/11 with diagnoses of dementia with conditions listed elsewhere without behavior disturbances, congestive heart failure and after care for traumatic fracture of the hip.</p> <p>The residents's most recent quarterly MDS assessment, dated 12/15/11, documented the resident:</p> <ul style="list-style-type: none"> * Had severe cognitive impairment, * Required extensive assistance for transfer, dressing, personal hygiene and bathing, * Was incontinent of bowel and bladder. <p>The resident's comprehensive care plan, dated 6/7/11, listed a problem of, "Self Care Deficit related to cognitive impairment." One of the interventions was, "Ensure and assist with grooming needs, comb hair, wash face, hands, oral hygiene, and shaving as needed."</p> <p>On 1/22/12 at 5:15 p.m. Resident #8 was brought into the dining room by a facility staff member. The resident's hair was standing up on the sides and back. It appeared that the resident had just got up from being in bed. In addition, the resident had several days of whisker growth on his chin, neck and cheeks and the CNA put a clothing protector on the resident without asking if he wanted one. CNA#1 was questioned and confirmed that the staff had not groomed the resident prior to bringing him to supper.</p> <p>The Administrator and DON were informed on 1/25/12 at 4:45 p.m. of the grooming problems. No further information obtained.</p> <p>2. Resident #1 was admitted to the facility on</p>	F 241	<p>CNA #3 was provided re-education on or before 2/23/12 by the Director of Nursing Services/Designee related to asking if residents would like a clothing protector prior to application and the importance of respecting resident dignity and promoting resident choice.</p> <p>2. An audit was completed on or before 2/08/12 by Nurse Management Team to ensure residents are shaved, hair is groomed, and clothes are clean. An audit was completed on or before 2/20/12 by the Director of Nursing/Designee to ensure residents are asked if they would like to use a clothing protector prior to application. One additional resident identified during the audit who was noted to be in need of a shave was provided with an electric shaver to enable self cares.</p> <p>3. Facility staff were re-educated to identify residents individualized needs related to: asking residents if they would like to use a clothing protector, shaving/grooming preferences, style of hair and appearance of clothing, or any other personal needs on or before 4/02/12 by the Director of Nursing or Staff Development Coordinator.</p> <p>Care plans were updated to reflected individuals who request to use clothing protectors or specialized grooming equipment by the Interdisciplinary Team on or before 4/2/12.</p>	
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F 241	<p>Continued From page 2</p> <p>10/20/11 with diagnoses that included acute renal failure, status post cholecystotomy, sick sinus syndrome, atrial fibrillation, cerebral vascular accident, and a chronic non-healing wound in his right lower extremity.</p> <p>On 1/22/12 at 4:15 pm, Resident #1 was observed in his room. The resident's family member was present during this observation. The resident's family member pointed out to the surveyor the resident had not been shaved that day. The surveyor observed the resident had visible hair growth on his face. The resident's hair had not been combed and the sweatshirt he was wearing had stains, possibly from his previous meals that day, on the front.</p> <p>Resident #1 was observed in the dining room at 5:30 pm that same day. The resident still had not had his hair combed, been shaved, nor had his dirty shirt changed.</p> <p>A review of the Resident Functional Performance Record form for January 2012 for Resident #1 documented he received a shower on 1/19/12 and required extensive assistance with the help of one person for grooming, dressing and undressing, and bathing. According to the facility Bath Schedule, Resident #1 received showers on Mondays and Thursdays.</p> <p>The resident's Care Plan documented in the focus area, "Self Care Deficit, requires assistance with ADL's...", the following interventions: * Allow sufficient time for dressing and undressing, since the task may be tiring, painful, and difficult. * Baths and showers per schedule and PRN [as</p>	F 241	<p>The IDT was re-educated on the importance of updating the residents plan of care and care cards when new interventions were identified.</p> <p>The IDT will be re-educated to the Customer First Program and ambassadors will be assigned to each resident to assist with promoting staff and resident communication and resident satisfaction and team building.</p> <p>4. Beginning the week of 4/02/12, Customer First rounding audits will be completed by the Interdisciplinary Team (IDT), as assigned by the Administrator four days weekly, for two months and two times weekly for four months to ensure patients are shaven, have their hair combed and have clean clothing on and that staff are asking residents if they would like a clothing protector prior to application. Findings from the rounds are corrected at the time of the occurrence in addition to reported at the next morning meeting. A summary of the audits will be submitted to the PI Committee for review and recommendations monthly for six months to evaluate systematic compliance and assure employee education has been maintained.</p>	
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F 241	<p>Continued From page 3 needed]. Skin check, shower, shampoo hair, nail cares, and lotion, PRN. * Ensure and assist with grooming needs, comb hair, wash face, hands, oral hygiene, and shaving as needed. * Make consistent dressing and grooming routine to provide a structured program to decrease confusion.</p> <p>On 1/23/12 at 7:10 am, CNA #3 was asked if there was a schedule for shaving residents. CNA #3 stated that there was not a schedule, that residents were shaved "when they need it." She replied that Resident #1 was not shaved every day because he "doesn't need it." She stated she did not know when he was shaved last because they do not document when they shave a resident.</p> <p>A Grievance/Complaint Reports for Resident #1, filed by a family member, documented on 10/23/11, the resident's family member was upset because Resident #1 did not receive a shower and shave on 10/21/11. The resident was showered and shaved on 10/23/11.</p> <p>The Administrator, DON, and other clinical professionals were informed of these issues on 1/26/12 at 11:00 am. No further information was received from the facility regarding this matter.</p>	F 241	<p>Ongoing education will be provided to the facility employees on a quarterly basis and at the time of hire for new employees by the Staff Development Coordinator (SDC) regarding assuring that the residents are provided care and service in a manor tailored to meet their individual needs. The PI Committee will re-evaluate the need for further monitoring and education after six months. The facility Administrator will assure compliance.</p> <p>Date of Compliance: 4/04/2012</p>	
F 246 SS=D	<p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES</p> <p>A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be</p>	F 246		

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F 246	<p>Continued From page 4 endangered.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, it was determined the facility failed to accommodate the needs of one resident. This was true for 1 of 13 (#s 1) sampled residents. Resident #1 had an arm rest attached to the wheelchair, as well as his left leg wheelchair support extended at a 45 degree angle, which resulted in the resident's chair not fitting under the tables in the dining room. Findings include:</p> <p>1. Resident #1 was admitted to the facility on 10/20/11 with diagnoses that included acute renal failure, status post cholecystectomy, sick sinus syndrome, atrial fibrillation, cerebral vascular accident with left hemiparesis and hemiplegia, and a chronic non-healing wound in his right lower extremity.</p> <p>The Physician Order [recapitulation] for January 2012 documented, "OT [occupational therapy] recommends left 1/2 tray to w/c [wheelchair] for left upper extremity positioning," dated 10/27/11.</p> <p>Resident #1 was observed during a breakfast observation on 1/23/12 at 7:45 am. The surveyor observed the Activities Director attempting to push the resident up to the table in his wheelchair. The resident's left 1/2 tray to his wheelchair had been flipped over to the side of his wheelchair, however, the hinge still blocked the resident from fitting under the table. In addition, the resident's</p>	F 246	<p>F246</p> <p>1. Resident # 1 had his armrest and wheelchair leg support adjusted on 1/22/12 to allow placement under the dining room table by the therapist. Resident #1 was discharged from the facility on 1/29/12.</p> <p>The Activity Director was re-educated on or before 2/22/12 by the Director of Nursing/Designee regarding wheelchair leg support and lap tray positioning to allow placement under the dining room table.</p> <p>The Therapy Program Manager was re-educated on or before 4/02/12 by the Regional Therapy Director regarding wheelchair leg support and the need to accommodate resident's needs to sit appropriately at the dining room table.</p> <p>2. An audit for resident's adaptive wheelchair or positioning equipment was completed on or before 4/02/12 by an Occupational Therapist to ensure resident are able to position under the table while in the dining room. The residents care plans and care cards were updated by the licensed nurse or therapist as needs were identified.</p> <p>The dining room tables were assessed by the Occupational Therapist (OT) on or before 4/02/12 to ensure accommodations are available for resident's requiring specialized wheelchairs or adaptive equipment.</p>		

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F 246	Continued From page 5 left leg was extended at a 45 degree angle and was hitting the support under the table, blocking the resident from fitting under the table as well. These hindrances kept the resident from fitting under the table at an appropriate distance and angle. The Therapy Director approached the surveyor and stated the resident's left leg had to be at a 45 degree angle of extension as it caused him pain to have it flexed at a 90 degree angle. There was no documentation of this issue in the resident's medical record. At 10:10 am, Resident #1 was observed in physical therapy with the Therapy Director. The Therapy Director removed the left tray from the resident's wheelchair, with some difficulty in removal noted. It was also noted the Therapy Director had the resident's left leg wheelchair support at a 90 degree angle and the resident was observed to report no difficulty or pain with flexion at that angle. There had been no accommodation of Resident #1's needs to sit appropriately at the dining table. He was observed on 1/22/12 to have stains down the front of his sweatshirt, reported to be food stains by his family. Please see F241 as it relates to resident grooming. The Administrator, DON, and other clinical professionals were informed of this issue on 1/26/12 at 11:00 am. No further information regarding this matter was received from the facility.	F 246	3. The Therapy Staff and the IDT were re-educated by the Regional Therapy Director on or before 4/2/12 regarding the resident's position for dining. Dining room observations will be conducted weekly by the OT in conjunction with a Nursing Manager to identify residents that require additional seating and positioning interventions in the dining room. Identified residents will be screened by the OT for further therapy treatment. 4. Starting the week of 4/02/12 the Nutritional Service Director/IDT as assigned by the Administrator will complete an audit four times weekly for two months and two times weekly for four months to ensure resident's are positioning at dining room tables. An OT will monitor one meal per week for 6 months to identify any additional needs based on dining room observations. A summary of the audits will be submitted to the PI Committee for review and recommendations monthly for six months to evaluate systematic compliance and ensure employee education has been maintained. Ongoing education will be completed on wheelchair positioning by the OT and SDC quarterly for facility staff and during orientation for new hires. The PI Committee will re-evaluate the need for further monitoring and education after six months. The Administrator will be responsible for compliance. Date of Compliance: 4/04/2012		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and	F 248			

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F 248	Continued From page 6 the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation and medical record review, it was determined the facility failed to ensure that Resident #3 received activities during the day. This was true for 1 of 13 (#3) sampled residents. The lack of activities being provided to the resident potentially could lead to problems with self worth and feelings of isolation. The resident had attended many activity programs prior to a move to a different unit. Findings include: 1. Resident #3 was admitted to the facility on 7/23/08 with diagnoses of head injury unspecified, liver injury without mention open wound, and other convulsions. The most recent quarterly MDS assessment, dated 10/21/11, documented the resident: * Had short and long term memory problem, * Had severe impairment in decision making skills, * Required total assistance with transfers, dressing, eating, personal hygiene and bathing. The Annual MDS assessment dated 1/25/11 documented the resident's activity preferences to be: *"Listening to music." *"Spending time outdoors." Resident #3's Activity care plan, dated 1/24/10, documented, "Activity Care Plan: [Resident #3]	F 248	F248 1. Resident #3's radio was turned to a volume that could be heard on 1/24/12 by the Director of Nursing. On 1/25/12 the nurse aide transported the resident to activities. The resident's daily schedule was reviewed by the Activities Director on or before 3/20/12 and the resident to determine an activities program that meets the resident's needs and likes/dislikes. An evaluation of the environment was completed and identified that headphones would benefit the resident's ability to hear and enjoy the t.v. and radio, which were provided to the resident of 1/30/12 date by the center. 2. An audit of residents who are dependent on staff to participate in activities was completed by Administrator or Designee on or before 2/13/12 to ensure residents are assisted to activities per plan of care. Resident interviews were conducted on or before 4/02/12 by the Activities Director to evaluate activities preferences in relation to the current activity program		

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F 248	Continued From page 7 has a diagnosis of head trauma/brain injury. She participates in activity programs daily to the best of her ability by blinking or my using hand movements [sic]. She is in her tilt and space wheelchair when she is out of bed which assists in keeping her properly positioned. [Resident #3] is also able to grab things and use her right arm and her pointer finger and thumb to grab thing [sic]. She is alert and needs assistance propelling her wheelchair. [Resident #3] receives visits from friends and family." The Interventions were: ** Offer activity program directed toward specific interests/needs of resident such as Recognizing that any response from [Resident #3] may be attempts to appropriately respond to stimuli, Give ample time for [Resident #3] to respond, Watch [Resident #3's] face for signs and symptoms of discomfort and Explain why we are there and give her a chance to decline the visit or invitation. [Resident #3's] preference in music is KBER 101.5 fm. * Provide 1:1 visits weekly. * Respect resident's choice in regard to limited/no activities. * Transport resident to activities. Assist in transporting any health-related equipment to activities. * Will reassess periodically for changes in preferences interests and ability. * Will take [Resident #3] to appropriate activities that will stimulate her and she can observe." There were multiple observations throughout the survey of the resident not having activities or stimulus provided. The observations were: * On 1/22/12 the resident was lying in bed at 4:35	F 248	3. Re-education was provided by the Administrator on or before 4/02/12 the facility staff and IDT related to assisting dependent residents to participate in activities. To further engage participation the activities times have been extended into the evening to increase the variety of events offered. Resident outings have been increased to twice a month as a result of the resident interviews conducted by the Activities Director. Individualized plans of care were updated from the interviews on or before 4/02/12 Activities Director and IDT.	
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F 248	<p>Continued From page 8</p> <p>pm and 5:45 pm with the head and knees of the bed elevated. The resident was awake and looking about the room. The radio was not on and the resident's roommates TV was playing loudly. The privacy curtain was pulled between the beds so the resident could not have seen the TV.</p> <p>* On 1/23/12 at 7:10 a.m. until 10:50 a.m. Resident #3 was observed to be in bed. The resident was in the same position as the previous night. The radio was not turned on. The resident was taken to the Sports Lounge. The Sports Lounge had the TV playing. At 11:10 a.m. the resident was taken back to her room so OT could do a staff inservice. The resident was back in the Sports Lounge at 12:15 p.m. The resident was sleeping in the wheelchair in the lounge at the 1:15 p.m. observation.</p> <p>* On 1/24/12 at 9:00 a.m. the resident was observed in bed with the head and knees elevated. The radio was turned on to the station of preference, but it was hard to hear because the resident's roommate had the TV turned up loud and the privacy curtain was pulled so Resident #3 could not see it. The resident remained in bed and was observed throughout the day until 2:15 p.m. On observation from 1:30 to 2:15 p.m. the resident was wide awake, attempting sit up and to lean against the wall in bed. The resident was not taken to any facility activities on this day.</p> <p>The resident was moved to the current room on 1/20/12. Review of the activity "Program Participation Record" for January 2012 revealed the resident attended a TV activity on 1/21/12 but had not attended any since then, and the activity staff did a 1:1 with her on 1/23/12.</p> <p>The administrator and DON were informed on</p>	F 248	<p>4. Starting the week of 4/02/12 IDT as assigned by the Administrator will complete an audit of activity participation records four times weekly for two monthly and two times weekly for four months to ensure dependant residents are assisted to activities per plan of care. A summary of the audits will be submitted to the PI Committee for review and recommendations monthly for six months to evaluate systematic compliance and ensure employee education has been maintained. Ongoing education will be provided to the facility staff by the Activities Director on a quarterly basis and during orientation for newly hired employees. The Performance Improvement Committee will re-evaluate the need for further monitoring and education after six months. The Activities Director will be responsible for compliance.</p> <p>Date of Compliance: 4/04/2012</p>	
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<p>F 248</p> <p>F 253 SS=D</p>	<p>Continued From page 9</p> <p>1/25/12 at 4:45 p.m. of the observation. No further information was obtained.</p> <p>483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Based on a complaint from the general public and observation, it was determined the facility failed to maintain residents' rooms in a safe and sanitary manner by a) having a dirty bedside commode and toilet, b) stains on an arm support on a wheelchair, and c) closet doors not properly attached to a track. This was true for 1 of 14 (#1) sampled residents. Findings included:</p> <p>Resident #1 was admitted to the facility on 10/20/11 with diagnoses that included acute renal failure, status post cholecystotomy, sick sinus syndrome, atrial fibrillation, cerebral vascular accident with left hemiparesis and hemiplegia, and a chronic non-healing wound in his right lower extremity.</p> <p>a. On 1/22/12 at 4:15 pm, Resident #1's room was observed to have a bedside commode next to his bed. The surveyor observed dried urine on the seat of the bedside commode and the interior had dried urine in the bottom of the receptacle. On 1/23/12 at 7:10 am and at 8:30 am, the bedside commode in Resident #1's room was again observed to have urine dried on the seat and inside the receptacle. It appeared to look the</p>	<p>F 248</p> <p>F 253</p>	<p>F253</p> <p>1. Resident #1's toilet was cleaned on 1/23/12 by housekeeping.</p> <p>Resident #1's wheelchair armrest was cleaned on 1/26/12 by housekeeping. The bedside commode was removed from the resident's room on 1/24/12 by Director of Nursing due to non-use. Resident #1's closet door was put back on track on 1/25/12 by the Maintenance Director. Resident #1 has been discharged from the center on 1/29/12.</p> <p>2. An audit of wheelchairs, toilets and bedside commodes was completed on or before 2/08/12 by the housekeeping supervisor related to cleanliness. A center wide audit of closet doors was completed on or before 2/08/12 by the Maintenance Director to ensure closet doors remains on track.</p> <p>3. Re-education has been provided to Housekeeping staff, facility staff and IDT on or before 4/02/12 by the Administrator or Designee related to the facility standard of maintaining clean wheelchairs and toilets, including bedside commodes. The Maintenance Director was re-educated by the Administrator on or before 2/15/12 related to maintaining closet doors in working order.</p> <p>Re-education has been provided to facility staff on or before 4/02/12 by the Maintenance Director on utilizing the maintenance log/work orders to notify the department of physical plant needs.</p>	
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F 253	Continued From page 10 same as the day before and had not been cleaned. On 1/22/12 at 4:15 pm, Resident #1's toilet was observed to have feces splattered inside the bowl. Resident #1 was dependent on staff for toileting assistance and this sanitation problem should have been seen by staff when assisting the resident. On 1/23/12 at 8:30 am, the toilet was observed to have been cleaned but on 1/24/12 at 8:45 am, Resident #1's toilet was again observed to have feces splattered inside the toilet bowl. b. On 1/22/12 at 4:15 pm, Resident #1's left arm support on his wheelchair was observed to have numerous stains on the material covering the support. These stains were observed on this arm support throughout the survey week. c. On 1/24/12 at 8:45 am, Resident #1's closet doors were observed to be off their tracks, making them difficult to move. The resident remarked the doors had been that way since he was admitted. The Administrator, DON, and other clinical consultants were informed of this issue on 1/26/12 at 11:00 am. No further information regarding this matter was received from the facility.	F 253	A cleaning schedule for wheelchairs, toilets, and bedside commodes was reevaluated and adjusted on or before 4/02/12. 4. Starting the week of 04/02/12 an audit of wheelchairs and toilet/bedside commodes will be completed by the Housekeeping Supervisor, and Interdisciplinary Team four times weekly for two months and two times weekly for four months to ensure equipment is cleaned as needed. An audit of resident closet doors will be completed by the Maintenance Director or Designee weekly for one month and monthly for two months to ensure closet doors remains in working orders. A summary of the audits will be submitted to the PI Committee for review and recommendations monthly for six months to evaluate systematic compliance and employee education has been maintained. Ongoing environmental cleanliness reeducation will be provided to the facility staff by the Environmental Services Director and Maintenance Director quarterly and during orientation for newly hired employees. The PI Committee will re-evaluate the need for further monitoring and education after six months. The Administrator will be responsible for compliance.		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or	F 280	Date of Compliance: 4/04/12		

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F 280	<p>Continued From page 11 changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on a complaint from the general public, record review, family interview, and staff interview, it was determined the facility failed to interview and include information from the resident family for making a comprehensive care plan and/or update care plans to reflect changes in resident's status. The facility failed to obtain information timely from family for the development of Resident #1's initial care plan. Resident #4's care plan was not updated to reflect medication changes or a change in ambulation status. Resident #7's care plan did not reflect changes related to skin integrity and ADL refusals. This was true for 3 of 9 (#1, #4 and #7) sampled residents. Findings included:</p> <p>A complaint from the general public stated family was not included in the development of the initial</p>	F 280	<p>F280</p> <p>1. Resident #1 was discharged from the center on 1/29/12. The MDS Coordinator was re-educated regarding the need to involve family/resident in the development of the plan of care on or before 2/27/12 by the Director of Nursing/Designee. Resident #4's care plan was updated on or before 2/27/12 by the IDT to reflect current interventions and condition. Resident # 7 was discharged from the center on 2/21/12.</p> <p>2. Resident care plans were audited by the IDT on or before 4/02/12 to ensure care plans reflect the current resident condition, goals, and interventions.</p>	
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F 280	<p>Continued From page 12 care plan for an identified resident.</p> <p>1. Resident #1 was admitted to the facility on 10/20/11 with diagnoses that included acute renal failure, status post cholecystectomy, sick sinus syndrome, atrial fibrillation, cerebral vascular accident with left hemiparesis and hemiplegia, and a chronic non-healing wound in his right lower extremity.</p> <p>During an interview with a family member on 1/22/12 at 4:15 pm, it was reported to the surveyor that no care plan discussion was held with the family until 12/16/11, 57 days after the resident was admitted to the facility. A review of Interdisciplinary Progress Notes for Resident #1 documented on 12/7/11, "Care Meeting:...We have attempt [sic] to reach [family member] several times and [family member] has not returned phones [sic]. We had a care meeting set up for 12/5/11 with [family member]-[family member] called and cancelled [sic] the meeting and we have attempted x 3 as of this date to reschedule the meeting without success..." There were no notes prior to 12/7/11 to document the facility had attempted to involve the family in the resident's comprehensive assessment and care plan development.</p> <p>On 1/25/12 at 1:30 pm, the MDS Coordinator was interviewed regarding there being no family interviewed in the initial comprehensive care plan. The MDS Coordinator stated she was not aware the family should have been included in the interviews to develop the assessment and care plan and that it was an "oversight" on the part of the facility that they had not been including family input into the assessment and care-planning</p>	F 280	<p>3. Re-education has been provided to the IDT and licensed nurses related to the requirements of updating care plans to reflect resident current condition and interventions by the Director of Nursing Services on or before 4/02/12.</p> <p>The Social Services Designee and Admission staff was re-educated on 4/02/12 by the Administrator related to documenting attempts to set up care plan meetings.</p> <p>Members of the IDT will review care plans associated with new orders, a resident's change in condition, scheduled assessments morning and/or weekly meeting(s) to assure that the resident's plan of care meets their current needs.</p>		

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F 280	<p>Continued From page 13 process.</p> <p>The Administrator, DON, and other clinical consultants were informed of this issue on 1/26/12 at 11:00 am. No further information was received regarding this matter.</p> <p>2. Resident #4 was admitted to the facility on 2/5/01, and readmitted on 1/1/10 with diagnoses of congestive heart failure, obesity, hypertension and status post uterine and breast cancer.</p> <p>a. A Behavior Monthly Flow Sheet for 11/11 listed Xanax 0.5 milligrams was being given for the diagnosis of anxiety. The resident's current Psychotropic Drug Use Care Plan, initiated on 2/28/11 and updated on 10/11/11, identified a diagnosis of anxiety that required pharmacological intervention.</p> <p>The resident's 1/12 physician's orders failed to include the Xanax, and the DON was interviewed on 1/24/12 at 11:00 a.m. in regard to the status of the medication. She stated the Xanax had been discontinued per telephone order on 11/13/11.</p> <p>The resident had a significant change MDS assessment on 1/7/12, but the care plan had not been updated to reflect the discontinuation of the medication for anxiety.</p> <p>b. The resident's current Fall Care Plan, dated 1/1/10 with a target date of 4/5/12, included interventions for proper foot wear, use of hand rails and assistive devices and a clutter free environment. The resident was care planned for a</p>	F 280	<p>4. Starting the week of 04/02/12 the Interdisciplinary Team will complete a random audit of five resident care plans three times weekly for two months then two residents care plans three times weekly for four monthly to ensure care plans reflect resident's current condition and interventions. A summary of the audits will be submitted to the PI Committee for review and recommendations monthly for six months to evaluate systematic compliance and ensure employee education has been maintained. Ongoing education will be provide to the IDT and licensed nursing staff on a quarterly basis and during orientation for newly hired employees. The PI Committee will re-evaluate the need for further monitoring and education after six months. The Director of Nursing will be responsible for compliance.</p> <p>Date of Compliance: 4/04/12</p>		

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F 280	<p>Continued From page 14 2 person Hoyer lift for all transfers.</p> <p>The DON was interviewed on 1/24/12 at 11:00 a.m. in regard to the transfer/ambulation status of the resident. She confirmed the resident had been non-ambulatory for a long period of time and the interventions should have been removed from the care plan.</p> <p>3. Resident #7 was admitted to the facility on 9/29/09 and readmitted on 1/30/11, with diagnoses of paralysis agitans, dementia, failure to thrive, seizure disorder, dysphagia and history of falls.</p> <p>a. The resident's Bathing Care Plan, dated 2/16/10 with a target date of 3/29/12, documented the resident required assistance with bathing related to his cognitive impairment and impaired mobility.</p> <p>Interventions were listed as, *Notify family if resident refuses showers, *Provide as much privacy as possible by pulling curtains and closing doors, *Provide consistent bathing routine, and *Provide positive reinforcement for success with tasks accomplished. No other interventions were listed.</p> <p>Bathing records were reviewed for 8/11 through 1/12 and refusals were documented 1 time in 10/11, 3 times in 11/11 and 2 times in 12/11. No documentation was present in the record to document the outcome if or when the family was called in the event of refusals.</p> <p>The DON was informed of the finding on 1/24/12 at 10:45 a.m. No further information was provided</p>	F 280		
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F 280	Continued From page 15 by the facility. b. The resident's Skin Care Plan, dated 2/16/10 with a target date of 3/29/12, documented the resident was to have heel protectors bilaterally in bed to promote skin integrity. The resident was observed on 1/22/12 at 4:20 p.m., 1/23/12 at 7:07 a.m. and 1/24/12 at 9:00 a.m. to be in bed without heel protectors in place. The DON was informed of the finding on 1/24/12 at 10:45 a.m. She stated the heel protectors had been discontinued and the plan was to float heels in bed. No further information was provided by the facility.	F 280		
F 285 SS=D	483.20(m), 483.20(e) PASRR REQUIREMENTS FOR MI & MR A facility must coordinate assessments with the pre-admission screening and resident review program under Medicaid in part 483, subpart C to the maximum extent practicable to avoid duplicative testing and effort. A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental illness as defined in paragraph (m)(2) (i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission; (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires	F 285	F285 1. Resident #6 has been re-evaluated by the physician extender and Regional Medicaid Unit on or before 2/29 /12. A Level 2 PASSAR was received from the Regional Medicaid Unit by the admission coordinator. 2. An audit of residents meeting level 2 PASSAR criteria was completed on or before 2/08/12 by the Health Information Manager to ensure a level 2 PASSAR is on file as required.	

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F 285	<p>Continued From page 16</p> <p>specialized services for mental retardation.</p> <p>(ii) Mental retardation, as defined in paragraph (m)(2)(ii) of this section, unless the State mental retardation or developmental disability authority has determined prior to admission--</p> <p>(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and</p> <p>(B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation.</p> <p>For purposes of this section:</p> <p>(i) An individual is considered to have "mental illness" if the individual has a serious mental illness defined at §483.102(b)(1).</p> <p>(ii) An individual is considered to be "mentally retarded" if the individual is mentally retarded as defined in §483.102(b)(3) or is a person with a related condition as described in 42 CFR 1009.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff interview, it was determined the facility failed to ensure residents with a diagnosis of mental retardation were screened upon admission for the need for specialized services. Without the assessment for the need for specialized services for the resident with mental retardation, there could be no determination as to whether the facility could meet the resident's needs for these services. This was true for 1 of 1 (#6) residents sampled with mental retardation. Findings included:</p> <p>Resident #6 was admitted to the facility on</p>	F 285	<p>3. Re-education was provided to the Admission Coordinators, Health Information Manager, and Social Service Designee by the Administrator on or before 4/02/12 related to level 2 PASSAR requirements. New page protectors were placed in charts to hold the PASSAR to avoid damage and thinning from the medical record on or before 4/2/12.</p> <p>4. Starting the week of 04/02/12 an audit of PASSARs will be completed by the Interdisciplinary Team weekly for 6months to ensure level 2 PASSARs are obtained as needed. A report will be submitted to the PI Committee for review and recommendations monthly for six months to evaluate systematic compliance and employee education has been maintained. Ongoing education will be provided quarterly to the IDT by the Health Information Manager on the admission process and when it is necessary to obtain a Level 2 PASSAR. The PI Committee will re-evaluate the need for further monitoring and education after six months.</p> <p>Date of Compliance: 4/04/12</p>		

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F 285	<p>Continued From page 17</p> <p>3/11/95 and readmitted on 8/30/04 with diagnoses that included depressive disorder, major refractory depression, other specified infantile cerebral palsy, mild intellectual disabilities, urinary frequency, and constipation.</p> <p>The resident's most recent quarterly MDS assessment, dated 12/21/11, documented the following:</p> <ul style="list-style-type: none"> * Understood by others and others able to understand resident * Brief Interview of Mental Status [BIMS] score of 8, moderately impaired * No signs or symptoms of delirium * Felt down, depressed, or hopeless for 2-6 days in the last 14 days * Felt bad about self for 2-6 days in the last 14 days * No rejection of care * Incontinent of bowel and bladder * No toileting program * Receiving antidepressant <p>A review of the resident's medical record indicated the Pre-Admission Screening and Resident Review [PASRR] form, dated 8/30/04, documented the following:</p> <ul style="list-style-type: none"> * The individual had a diagnosis of mental retardation. * The individual had a history of mental retardation or developmental disability. * The individual had presenting evidence that indicated the person had mental retardation or developmental disability. * The individual was not referred by an agency that served persons with mental retardation or developmental disability or had been eligible for that agency's services. 	F 285		
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F 285	<p>Continued From page 18</p> <p>The PASRR directed that if the answer was yes to any of the questions, screening for the need for specialized services had to be conducted by the designated Departmental unit.</p> <p>On 1/25/12 at 9:00 am, the DON was asked to provide documentation that Resident #6 was screened for the need for specialized services at the time of his admission by the appropriate department. On 1/26/12 at 10:30 am, the Administrator informed the surveyors he believed this screening did not have to be performed because of the resident's original admission date in 1995. The Administrator was informed this screening for specialized services had been required since 1989. The Administrator stated they could not find this secondary screening PASRR for Resident #6.</p> <p>The Administrator, DON, and other consulting professionals were informed of this issue on 1/26/12 at 11:00 am. No further information was received from the facility regarding this matter.</p> <p>The Medicaid agency was contacted by email on 02-01-12 and questioned as to whether Resident #6 ever had a Level II PASRR. Medicaid personnel confirmed that no Level II PASSR had been completed.</p>	F 285		
F 309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment</p>	F 309		

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F 309	<p>Continued From page 19 and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and records review, it was determined that facility had failed ensure 2 of 13 (#1 and #3) sampled residents received care according to the care plan, so that each resident's highest practicable status could be maintained. Resident #3 was not positioned properly in her adaptive wheelchair and did not have on a cervical collar according to her care plan, which resulted in placing the resident's neck in a hyper-flexed position. This position had the potential to cause respiratory obstruction. Resident #1 did not have the call light and water placed within reach as outlined on the care plan.</p> <p>Findings include:</p> <p>1. Resident #3 was admitted to the facility, on 7/23/08, with diagnoses of head injury unspecified, liver injury without mention open wound, and other convulsions.</p> <p>The most recent quarterly MDS assessment, dated 10/21/11, documented the resident: * Had short and long term memory problem, * Had severe impairment in decision making skills, * Required total assistance with transfers, dressing, eating, personal hygiene and bathing.</p> <p>The resident's care plan, dated 1/24/10, documented a problem of, "Self care deficit</p>	F 309	<p>F309</p> <p>1. Resident #3's cervical collar was applied on 1/23/12 by the nursing staff and the Occupational Therapist. Resident #3 was repositioned in the wheelchair on 1/23/12 by the nursing staff and the occupational therapist. Resident #1's call light and water were placed in reach on 1/23/12 by the nursing assistant. Resident #1 was discharged from the center on 1/29/12.</p> <p>CNA #3 was re-educated regarding the need to place the call light and water within the residents reach by the Director of Nursing/Designee on or before 2/20/12.</p> <p>2. An audit of wheelchair positioning and support device placement was completed on or before 4/02/12 by an OT to ensure residents are positioned in their wheelchair to meet the resident's needs and that supportive devices are applied per orders. The licensed nurse evaluated residents who required assistive devices including cervical collars to determine the schedule and frequency of the applications and validate the care plan and care cards reflected the schedule and frequency of the applications. This audit will be completed by 4/02/12.</p> <p>An audit of call light placement and water placement was completed on or before 2/23/12 by the IDT to ensure that call lights and water are within the reach of residents.</p>		

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F 309	<p>Continued From page 20</p> <p>related to: Late effects closed head injury, decreased mobility: positioning, locomotion/lack of limb/trunk control." Two of the interventions were:</p> <p>** Uses a tilt-n-space wheelchair with headrest for positioning and locomotion. Dependent on staff for locomotion.</p> <p>* [Resident #3] is to wear soft neck collar when out of bed."</p> <p>On 1/23/12 at 10:50 a.m. Resident #3 was observed to be mechanically lifted into her wheelchair by two staff members. The resident's wheelchair had a special adaptive headpiece with an occipital pad and temporal pad/stabilizer attached. CNA#2 was observed to attempt to adjust the headpiece to the resident's head, but could not move it. The resident's wheelchair was tilted about 75 degrees, which put the resident in a semi-upright position.</p> <p>At 10:55 a.m. the resident was transported to the "Sports Lounge" and left to watch television. The resident's head was hyper-flexed forward in the chair. The resident's chin was almost on her chest.</p> <p>At 11:10 a.m., after constant observation, the surveyor contacted the DON and informed her of the resident's positioning and concerns for respiratory issues from the neck being hyper-flexed forward. The DON brought the resident back to her room and contacted the Occupational Therapist [OT]. The OT did an inservice for the staff on proper positioning and using the headpiece attached to the wheelchair. The resident wheelchair had to be moved to about 60 degrees of tilt for the positioning to work properly.</p>	F 309	<p>3. Re-education was provided to the facility staff and IDT by an OT regarding wheelchair positioning and supportive device placement on or before 4/02/12.</p> <p>Positioning will be reviewed with quarterly, annual, and as needed assessments by the IDT. Concerns will be referred to the OT for evaluation and treatment if necessary.</p> <p>Re-education was provided to the facility staff and IDT regarding call light and water placement within reach of the resident on or before 4/2/12 by the Director of Nursing. This education also focused on shift to shift communication of the residents' condition and needs.</p>	
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F 309	<p>Continued From page 21</p> <p>The resident was to wear a soft cervical collar. The resident was observed to not have one applied until sometime after 12:15 p.m.</p> <p>The administrator and DON were informed 1/25/12 at 4:45 p.m. No further information was provided.</p> <p>2. Resident #1 was admitted to the facility on 10/20/11 with diagnoses that included acute renal failure, status post cholecystectomy, sick sinus syndrome, atrial fibrillation, cerebral vascular accident with left hemiparesis and hemiplegia, and a chronic non-healing wound in his right lower extremity.</p> <p>On 1/23/12 at 7:10 am, the resident was observed sitting in his wheelchair in his room. The resident was facing the television and was positioned with his over-the-bed table behind him. His call light was observed to be clipped to his bed and his water was on his over-the-bed table, both out of the resident's reach. The resident was asked if he could reach either the call light or his water and he responded he could not.</p> <p>The surveyor turned on the resident's call light and CNA #3 responded to the call light. CNA #3 came in and asked the resident what he needed. The surveyor informed the CNA that the call light had been turned on by her, not the resident, as the resident was incapable of reaching his call light, as well as his water. The CNA stated she had been in the room and had left to get a razor to shave the resident. The CNA had not returned with a razor and had to leave the room again to get a razor. The CNA did place the call light within the resident's reach before leaving the room</p>	F 309	<p>4. Starting the week of 04/02/12 an audit of wheelchair positioning, supportive device placement, call light placement and water placement will be completed by the IDT four times weekly for two month and two times weekly for four months to ensure residents are positioned as ordered in their wheelchairs, supportive devices are in place per orders, call lights are within reach and water is within reach. A summary of the audits will be submitted to the PI Committee for review and recommendation for six months. Ongoing education will provided quarterly by the SDC to the IDT, facility staff and during orientation of newly hired employees. The PI Committee will re-evaluate the need for further monitoring and education after six months. The Director of Nursing will be responsible for compliance.</p> <p>Date of Compliance: 4/04/12</p>		

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F 309	Continued From page 22 again. The resident's Care Plan for Self Care Deficit documented interventions of "Call light within reach and answer promptly" and "Provide equipment within easy reach." The Administrator, DON, and other clinical professionals were informed of this issue on 1/26/12 at 11:00 am. No further information regarding this matter was received from the facility.	F 309		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and medical record review, it was determined the facility failed to ensure that residents did not acquire pressure sores and they received appropriate treatment and care planning to heal pressure sores. This was true for 2 of 13 (#s 5 & 9) sampled residents. Findings include: 1. Resident #5 was admitted to the facility on 7/30/11, and readmitted on 1/18/12, with	F 314	F314 1. Resident #9's wound resolved on 1/15/12. The resident's care plan has been updated to reflect current condition and interventions by the Director of Nursing on or before 3/2/12. Resident #9 was re-evaluated by the Registered Dietician related to nutritional needs on or before 2/28/12. Resident #5's care plan was updated to reflect current skin condition and treatment on 1/23/12 by the Director of Nursing Services.	

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F 314	<p>Continued From page 23</p> <p>diagnoses of multiple sclerosis (MS), muscular wasting and disuse atrophy and two stage II pressure sores on her buttock.</p> <p>The most recent quarterly MDS, dated 11/9/11, documented the resident:</p> <ul style="list-style-type: none"> * Was cognitively intact. * Required extensive assist for transfers, dressing, eating, personal hygiene. * Had a catheter in place. * Did not have a pressure sore. <p>Resident #5's care plan documented a problem of: "Potential for skin breakdown related to advanced stages of MS. Norton score of 10 or less." The interventions were:</p> <ul style="list-style-type: none"> ** Treatment as ordered. * Report complaints of pain. * Report new open areas. * Administer meds as ordered. * Observe standard precautions. * Cushion to wheelchair. * LAL [low air loss] mattress. * Use positioning devices as ordered. * Weekly skin assessment." <p>There was no care plan for the actual pressure sores on the coccyx and treatments that the facility would use to resolve them.</p> <p>The "Pressure ulcer Documentation Form," dated 1/18/12, documented two stage II pressure sores on the coccyx. One measured 1.0 x 0.8 centimeters and the second measured 1.1 x 1.1 centimeters. Both were present on admission back to the facility from the hospital.</p> <p>The DON was interviewed on 1/24/12 at 2:45</p>	F 314	<p>2. An audit of residents at high risk for skin breakdown was completed by the IDT on or before 4/02/12 to ensure interventions for preventative measure are in place and that resident's care plan reflects current condition and interventions.</p> <p>3. Re-education was provided to the IDT and facility staff on implementation of preventive interventions for patients at high risk for skin breakdown. The education also included updating of care plans for residents with current skin breakdown and for residents who are at risk for skin breakdown by the Director of Nursing Services or Designee on or before 4/02/12.</p> <p>Skin assessments will be completed by a Registered Nurse (RN) on admission, quarterly, annual, and as needed. Weekly skin checks will also be completed by a licensed nurse and documented in the resident's medical record.</p> <p>Residents who develop a skin condition or alternation in skin integrity will have a root cause analysis completed at the time of identification. The physician will be notified and orders and interventions will be obtained and implemented.</p> <p>Members of the IDT will review the skin assessments, care plans and root cause analysis data during their morning and weekly meetings. Actions will be taken and interventions put into place as warranted based off of these reviews.</p>		

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F 314	<p>Continued From page 24</p> <p>p.m. and confirmed that the care plan was not updated to reflect the care the resident was receiving for the pressure sores.</p> <p>2. Resident #9 was admitted to the facility on 12/27/11 with diagnoses that included a non-displaced right hip fracture, chronic kidney disease, coronary artery disease, diabetes, and dementia.</p> <p>Resident #9's admission Nursing Assessment, dated 12/27/11 at 12:30 pm, documented the following:</p> <ul style="list-style-type: none"> * 2 person assist with transfers * No skin/wound conditions present * Primary risk factors for skin - crossed out and marked "n/a" [not applicable] * Norton Plus Pressure Ulcer Scale score of 10, Score of 10 or less = high risk <p>The resident's admission MDS assessment, dated 1/3/12, documented the following:</p> <ul style="list-style-type: none"> * Brief Interview for Mental Status [BIMS] score of 5, severely impaired * Extensive assistance requiring two persons for physical assistance for bed mobility and transfers * Indwelling catheter * Frequently incontinent of bowel * No malnutrition or risk of malnutrition * 1 unstageable deep tissue pressure ulcer <p>A consultation report from his hospitalization prior to admission, dated 12/22/11, documented the resident had fallen at home and received a non-displaced right hip fracture. This report also documented severe hyperkalemia and the remainder of his electrolytes within normal limits</p>	F 314	<p>4. Starting the week of 04/02/12 an audit will be completed by the IDT four times weekly for two months and two times weekly for four months to ensure residents at high risk for skin break down have preventive interventions implemented on the care plan and residents with current skin breakdown have a care plans related to the skin condition and treatment. A summary of the audits will be submitted to the PI Committee for review and recommendations monthly for six months to ensure that systematic compliance and employee education has been maintained. Ongoing education will be provided to the facility staff and IDT on prevention and treatment of pressure ulcers by the Director of Nursing quarterly and during orientation for newly hired employees. The PI Committee will re-evaluate the need for further monitoring and education after six months. The Director of Nursing Services will be responsible for compliance.</p> <p>Date of Compliance: 4/04/12</p>	
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NAME OF PROVIDER OR SUPPLIER IDAHO FALLS CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3111 CHANNING WAY IDAHO FALLS, ID 83404
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F 314	<p>Continued From page 25</p> <p>except for creatinine of 2.0 and a BUN [blood, urea, nitrogen] of 39. There was no mention in his comprehensive metabolic panel [CMP] of low protein or albumin levels.</p> <p>The Resident Functional Performance Records for December 2011 and January 2012 documented Resident #9 required extensive assistance of one person for physical assistance for bathing, toileting, and dressing and extensive assistance requiring one to two persons for physical assistance for bed mobility.</p> <p>A Non-Pressure Wound and Skin Condition Documentation Form for Resident #9 dated 12/29/11, documented the following:</p> <ul style="list-style-type: none"> * Site: Coccyx * Type: Excoriation * Date of Onset: 12/29/11 * Present at Admission: No * Wound measurements: Entire area * Resolved: 1/9/12 <p>NOTE: The admission Nursing Assessment dated 12/27/11 documented that there were no wounds or skin conditions. The excoriation of the resident's entire coccyx area developed in just two days.</p> <p>A Change of Condition Documentation form, dated 1/3/12 at 4:00 pm, documented that Resident #9 had an unstageable pressure ulcer on his coccyx, measuring 1.5 cm [centimeters] by 0.4 cm. Also documented was a new order for a low air loss [LAL] mattress for the resident, as well as an optifoam dressing.</p> <p>NOTE: The facility failed to identify the resident's</p>	F 314		
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F 314	<p>Continued From page 26</p> <p>deteriorating coccyx pressure wound at an early stage, even though there was documented evidence of excoriation present, and did not implement additional interventions to avoid further breakdown of his coccyx</p> <p>A Pressure Ulcer Documentation Form for Resident #9 dated 1/3/12, documented the following:</p> <ul style="list-style-type: none"> * Site: Coccyx * Date of Onset: 1/3/12 * Present at Admission: No * Wound measurements: 1/3/12, Unstageable, 1.5 cm length x 0.4 cm width x less than 0.1 cm depth 1/9/12, Stage 2 (reclassified), 1.4 cm length x 0.4 cm width x less than 0.1 cm depth 1/15/12, Resolved <p>The Interdisciplinary Progress Notes for Resident #9 documented no notations of the resident being repositioned in bed by staff until after the pressure ulcer had been identified. The first documentation of the resident being turned in these notes was on 1/4/12. On 1/16/12, an IDT note documented the wound had resolved.</p> <p>The resident's Care Plan documented the only intervention for repositioning was in the focus area of Pain, dated 12/27/11, and it included, "Assist to reposition for comfort." The focus area, Alteration in Skin Integrity Care Plan, included the following interventions on admission:</p> <ul style="list-style-type: none"> * W/C [wheelchair] cushion * Float heels when in bed <p>On 1/25/12 at 11:15 am, the DON was interviewed regarding interventions for Resident</p>	F 314		
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F 314	<p>Continued From page 27</p> <p>#9. The surveyor asked about the pressure reducing mattress utilized upon admission to the facility, whether this was a mattress used for someone who scored as a high risk for skin breakdown or if there was another level higher than this mattress. The DON stated this was a mattress used in general for admissions and that because the resident had a non-displaced hip fracture, he was not originally placed on the low air loss mattress, which he was placed on after his pressure ulcer was discovered. The DON stated the reason the resident had not been placed on a LAL mattress was she felt it might have increased his pain over his being placed on the general pressure reducing mattress. The DON also confirmed the intervention for frequent turning was not placed on the care plan until after the pressure ulcer was discovered and the only other mention of repositioning was in the Pain care plan.</p> <p>A physician progress note, dated 1/9/12, after the pressure ulcer had been discovered, stated: "[Resident] has poor PO intakes, averaging less than 50% intake of most meals. His albumin level is low at 3.3 and his Norton Score is 10. On admission to the facility, interventions put into place for [Resident] include a pressure reducing mattress, a w/c cushion and heels floated when in bed. Due to his medical condition and medical history, it is my opinion that skin breakdown is unavoidable."</p> <p>According to the federal regulations at 42 CFR 483.25(c), the following definitions apply to the determination of avoidable versus unavoidable pressure sores: "Avoidable/Unavoidable Pressure Ulcers</p>	F 314			

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F 314	<p>Continued From page 28</p> <ul style="list-style-type: none"> o Avoidable means that the resident developed a pressure ulcer and that the facility did not do one or more of the following: evaluate the resident's clinical condition & pressure ulcer risk factors; define & implement interventions that are consistent with resident needs, resident goals, & recognized standards of practice; monitor & evaluate the impact of the interventions; or revise the interventions as appropriate. o Unavoidable means that the resident developed a pressure ulcer even though the facility had evaluated the resident's clinical condition & pressure ulcer risk factors; defined & implemented interventions that are consistent with resident needs, goals, & recognized standards of practice; monitored & evaluated the impact of the interventions; & revised the approaches as appropriate." <p>The Total Protein and Albumin levels referenced in the 1/9/12 physician progress note was in regards to labs drawn on 1/5/12, two days after the discovery of the pressure ulcer. This CMP documented a Total Protein of 6.9 g/dl [grams per deciliter] and Albumin of 3.3 g/dl. NOTE: Normal levels for Total Protein were 6.3-8.2, documenting a normal Total Protein level and 3.5-5.0 for Albumin, documenting a low Albumin level. The resident's hospital report did not document low Total Protein nor low Albumin so these were discovered/documentated after the resident's admission to the facility and after the discovery of the Stage 2 pressure ulcer to the resident's coccyx.</p> <p>The facility had documented the resident was at high risk for development of pressure ulcers, had limited mobility due to the non-displaced hip</p>	F 314		
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F 314	Continued From page 29 fracture, and was dependent on staff for assistance with bed mobility and other activities of daily living. His pre-existing diagnoses and medical history were known as well, upon admission, yet the facility failed to implement preventive interventions, such as protein-enhanced meals, a low air loss mattress, and a turning/repositioning program. After the development of excoriation to his entire coccyx on 12/29/11, no interventions to prevent further impairment to skin integrity were implemented. The Administrator, DON, and other clinical consultants were informed of this issue on 1/26/12 at 11:00 am. No further information on this matter was received.	F 314		
F 320 SS=G	483.25(f)(2) NO BEHAVIOR DIFFICULTIES UNLESS UNAVOIDABLE Based on the comprehensive assessment of a resident, the facility must ensure that a resident whose assessment did not reveal a mental or psychosocial adjustment difficulty does not display a pattern of decreased social interaction and/or increased withdrawn, angry, or depressive behaviors, unless the resident's clinical condition demonstrates that such a pattern is unavoidable. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, it was determined the facility failed to provide psychosocial assessment, interventions, and referral to address a resident's psychosocial needs. The facility failed to identify worsening symptoms of depression for the resident and intervene to keep him from being harmed. The	F 320	F320 1. Resident # 6 received an order for Senior Counseling on 1/24/12 by the licensed nurse. Resident #6 began Senior Counseling the week of 1/30/12 to address resident's psychosocial needs. A significant change in status MDS was completed by the Interdisciplinary Team on or before 2/28/12. Resident #6's comprehensive care plan was updated to reflect current psychosocial needs and interventions to include needs related to refusal of care. The Social Services Designee met with resident on 2/21/2012 related to the resident loss of both parents and his grieving process.	

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F 320	<p>Continued From page 30</p> <p>facility failed to properly document or determine the underlying causes of his behaviors. The resident was subsequently harmed when he displayed a persistent depressed mood manifested by social withdrawal and disengagement, tearfulness, crying, loss of interest in activities, and apathy, also manifested by weight loss, skin rash and excoriation, and diminished appetite. The facility failed to review or evaluate the resident's care plan for depression, in spite of a preponderance of documentation to his psychosocial decline. This was true for 1 of 15 (# 6) sampled residents.</p> <p>Other negative consequences suffered by the resident were based on multiple refusals of care and included:</p> <ul style="list-style-type: none"> * Refusal of bathing resulting in rash and excoriation to his apron and scrotum, dry, flaky, feet and a strong urine odor in his room; * Refusal of activities, resulting in self-isolation and being withdrawn; * Refusal to allow staff to weigh him for days at a time, resulting in unknown gains and losses in weights; and * Refusal of meals and snacks, resulting in weight loss of 22 pounds, and a greater than 5% weight loss in September and October 2011. <p>Findings included:</p> <p>Resident #6 was admitted to the facility on 3/11/95 and readmitted on 8/30/04 with diagnoses that included depressive disorder, major refractory depression, other specified infantile cerebral palsy, mild intellectual disabilities, urinary frequency, and constipation.</p>	F 320	<p>2. An audit of residents with the diagnosis of depression and refusal of care was completed by the Social Service Director/Designee on or before 2/22/12 to ensure referrals to outside support/counseling services and interventions were implemented as needed. An additional audit was conducted by an outside Social Work Consultant on or before the week of 4/02/12 to identify any additional residents who exhibit signs of depression or refusal of care an to assure that the resident's psychosocial needs are being met.</p> <p>3. The Social Service Designee and the IDT have been re-educated regarding the need for psychosocial support of residents that have the diagnosis of depression and/or residents who refuse care by the Social Work Consultant on or before the week of 4/2/12. The Social Service Designee was re-educated by Consulting Social Worker on or before 4/2/12 related to accurate coding behaviors on the MDS. The IDT was re-educated on or before 4/2/12 by the Consulting Social Worker related to providing interventions for resident's behaviors and documenting the interventions.</p> <p>Behavior and Activities plans of care are reviewed by the IDT quarterly, annually, and as needed to ensure the care plans reflect the residents current needs and behaviors.</p>		

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F 320	<p>Continued From page 31</p> <p>The resident's most recent quarterly MDS assessment, dated 12/21/11, documented the following:</p> <ul style="list-style-type: none"> * Understood by others and others able to understand resident * Brief Interview of Mental Status [BIMS] score of 8, moderately impaired * No signs or symptoms of delirium * Felt down, depressed, or hopeless for 2-6 days in the last 14 days * Felt bad about self for 2-6 days in the last 14 days * No rejection of care * Extensive assistance requiring two persons for physical assistance with bed mobility, dressing, and toilet use * Total dependence requiring two persons for physical assistance with transfers * Extensive assistance requiring one person for physical assistance for locomotion on and off the unit, personal hygiene and bathing * Independent requiring set up help only for eating * Incontinent of bowel and bladder * No toileting program * Weight loss of 5% or more in the last month or 10% or more in last 6 months * Mechanically altered diet * Weight 250 pounds * At risk for developing pressure ulcers * Receiving antidepressant <p>The resident's most recent annual MDS assessment, dated 6/2/11, documented the following differences from the most recent quarterly MDS assessment:</p> <ul style="list-style-type: none"> * BIMS score of 12, moderately impaired * No symptoms of mood * Extensive assistance requiring one person for 	F 320	<p>Activities times were extended into the evening and additional training was provided by the Activities Director to the ID, activities staff and facility staff on or before 4/02/12 to ensure personalized activities are provided by the activities staff.</p> <p>4. Starting the week of 04/02/12 an audit will be completed by IDT as assigned by the administrator four times weekly for two months and two times weekly for four months to ensure psychosocial support and referral interventions are implemented for residents with a diagnosis depression and refusal of care as needed. A summary of the audits will be submitted to the PI Committee of review and recommendations monthly for six months to evaluate systematic compliance and employee education has been maintained. Ongoing education will be provided quarterly by the Social Work Consultant to the IDT on identifying residents who may require additional psychosocial support. The Social Work Designee will educate the facility staff and IDT during these education sessions on how to communicate concerns about a resident to the IDT for follow-up. The Performance Improvement committee will re-evaluate the need for further monitoring and education after six months. The Social Work Designee will be responsible for compliance.</p> <p>Date of Compliance: 4/04/12</p>		

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F 320	<p>Continued From page 32</p> <p>physical assistance with dressing</p> <ul style="list-style-type: none"> * Supervision with set up help for eating * Toileting program * No weight loss * Weight 269 pounds * Not at risk for developing pressure ulcers <p>The resident's January 2012 Physician (recapitulation) orders documented he received Lexapro 30 mg (milligrams) every day for depressive disorder not elsewhere classified, and Seroquel 25 mg at bedtime for major refractory depression.</p> <p>The resident's Care Plan identified in the focus, "Self Care Deficit, requires assistance with dressing, bathing, personal hygiene r/t [related to] decreased balance, lack of limb/trunk control, pain, physical limitations, weakness, CP [cerebral palsy]--Non-compliance r/t refuses cares frequently will jit [sic][not] allow staff in room, refuses incontment [sic] cares, repositioning in bed or w/c [wheelchair] refusing medications, meals and bathing," dated 12/22/11. Goals included, "Will be dressed daily by staff and Resident will follow bathing schedule as laid out by staff, with refusals respected. "Approaches included, "If [resident] refuses cares, reapproach him at a later time" and "Schedule a CP [care plan] meeting PRN [as needed] to update plan r/t [resident's] non compliance."</p> <p>The resident's October 2011-January 22, 2012 Resident Functional Performance Records documented the following:</p> <ul style="list-style-type: none"> * Grooming documented as refused or did not happen 39 days * Dressing/Undressing documented as refused or 	F 320			

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F 320	<p>Continued From page 33</p> <p>did not happen 7 days</p> <ul style="list-style-type: none"> * Received bed baths 20 times, due to refusing showers * Showers documented as refused 8 times * 4 Showers given during those months <p>NOTE: On 10/10/11, an Interdisciplinary Health Education Record noted the following:</p> <ul style="list-style-type: none"> - No identified barriers to learning - Educational need - Shower - Resident verbalized understanding <p>This record documented the following as the content of education:</p> <p>"Res [resident] was offered shower today. Res refused. Stated he did not want to get out of bed. Bed bath then offered. Res refused. Stated he did not want one. Discussed shower schedule et [and] need for res to take shower to prevent skin issues already in place. Res verbalized understanding et cont [continued] to refuse."</p> <p>NOTE: It was evident after this resident education documentation that the resident continued to refuse showers and the education had not been effective.</p> <p>The August 2011 to January 2012 MARs Behavior Monthly Flowsheets documented the following behaviors:</p> <p>August 2011</p> <ul style="list-style-type: none"> * 3 refusals of cares/meds [medications] and 2 episodes of self-isolation, no interventions documented <p>September 2011</p> <ul style="list-style-type: none"> * No behaviors documented <p>October 2011</p> <ul style="list-style-type: none"> * 19 episodes of depressed/withdrawn, 12 documented 1:1 intervention and 7 with no intervention documented, 13 documented 	F 320		
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F 320	<p>Continued From page 34</p> <p>outcomes as the same and 6 as improved November 2011</p> <p>* 7 refusals of cares, 2 documented no interventions, 4 documented redirection and 1 documented 1:1 intervention, with 2 documented as same outcome and 5 as improved December 2011</p> <p>* 3 episodes of isolates self, no interventions documented, outcome documented as improved January 2012</p> <p>* 1 episode of isolates self and 1 episode of depressed/withdrawn, no intervention documented, outcome documented as improved</p> <p>NOTE: Information documented on the Behavior Monthly Flowsheet was not consistent with information garnered through staff interviews at the time of the survey. See interviews documented below.</p> <p>The resident's refusals to participate in showers, grooming, dressing, and getting out of bed resulted in rashes and excoriation as identified below.</p> <p>Resident #6's Non-Pressure Wound and Skin Condition Documentation Forms documented problems with two different sites.</p> <p>The first site was identified as the resident's entire apron [area where the fatty tissue of the abdomen overhangs onto itself], with a date of onset of 9/15/11. It was not present on admission and documented as excoriation and having odor on 9/15/11. It was resolved as of 11/22/11.</p> <p>The second site was identified as the resident's scrotum, with a date of onset of 9/10/11. It was not present on admission and documented as a</p>	F 320			

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F 320	<p>Continued From page 35</p> <p>rash and having wound related pain on 9/10/11. It was resolved as of 11/22/11.</p> <p>The surveyor observed the resident lying in his bed, back turned towards the door, in the dark: * 1/22 at 5:30 pm, 1/23 at 7:10 am, 7:30 am, 8:15 am, 10:10 am, 2:00 pm, 1/24 at 8:45 am, 9:30 am, 10:30 am, 12:20 pm, 2:05 pm, and 3:10 pm. The resident was not observed out of his room until the morning of 1/25/12 when he went to the Beauty Shop to get a hair cut. He was never observed in his room with the light on except during the one observation of peri-care.</p> <p>On 1/24/12, the surveyor requested to observe peri-care for Resident #6. CNA staff were advised that morning the surveyor wanted to be apprised of any attempts or provision of peri-care for Resident #6. The resident was approached at 10:30 am, 12:20 pm, 2:05 pm and 3:10 pm and the resident refused to receive cares at every approach. The resident had received no peri-care during that entire time. The DON was informed of the resident's multiple refusals to receive cares at 3:10 pm. During these approaches, it was observed by the surveyor that the resident's room had a very strong odor of urine and the DON remarked they had changed his mattress due to this once already. The DON approached the resident and only after the DON promised to stay and eat dinner with the resident, did he agree to receive peri-care. The resident's Care Plan for Bowel and Bladder documented he was to be checked for incontinence in the morning, after meals, bedtime and routinely on rounds, at night and as needed. His Self-Care Deficit Care Plan documented that if the resident refused cares to reapproach him at a later time. There was no</p>	F 320		
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F 320	<p>Continued From page 36</p> <p>evidence of skin breakdown by the surveyor on observation but the resident's feet were edematous, very dry with flaking skin bilaterally and the skin on his buttocks was discolored a dark brown color. The DON stated she did not know the cause but it had always appeared discolored.</p> <p>Interdisciplinary Progress Notes [IPN] for Resident #6 documented the following:</p> <ul style="list-style-type: none"> * 8/3/11 "IDT Note: Resident has had a weight loss of 11 lbs [pounds] over the last month. COC [change of condition] sent to MD. Resident PO [oral] intakes average 45%. Resident is on Lexapro for depression and Seroquel for depression, last GDR [gradual dose reduction] attempt was in 3-11 [March 2011]. Resident continues to show signs of depression such as isolating himself and resisting cares at times." * 8/29/11 "Res refused noon and evening meds. Reapproached x 3 [three times]. MD notified." * 9/15/11 "Res refused to get out of bed today. Stated he wants to stay in bed because its shower day. Res given bed bath. Refuses showers. Antifungal powder applied to scrotum per orders." * 9/16/11 "Res cont [continues] with antifungal cream to apron excoriation. Res refused to get out of bed today. States he will tomorrow." * 10/20/11 "Res self isolating today. Refuses to get out of bed. Res is smiling et has no verbal or physical [illegible]. States he wants to stay in bed." * 11/9/11 "Care Meeting - weight down 34 lbs since July 1st. House ground diet. Will enhance his meals high calories, high protein snack... [resident] has had been [sic] refusing cares. He refuses to get out of his bed most days. Will 	F 320		
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F 320	<p>Continued From page 37</p> <p>schedule a family meeting to discuss non-compliance. Will also ask MD possibly of changing Lexapro to Remeron. Will cont to follow..."</p> <p>* 11/10/11 "Res refused to get out of bed today. Bed bath given. Res shaved. Res eats meals in room."</p> <p>* 11/25/11 "Pt refused to get up today even after encouragement."</p> <p>* 12/3/11 "...Pt has been refusing to be bathed and refusing to up in chair [sic]. Cream applied to excoriation/red areas buttocks [sic]."</p> <p>NOTE: Although there were no Non-Pressure Wound and Skin Documentation forms, it appears from this note that the excoriation had reoccurred.</p> <p>* 12/6/11 "Pt continues to get up into chair and continues to refuse aides to clean him up..."</p> <p>* 12/14/11 "Rash decreased...Pt continues to not get up..."</p> <p>* 12/28/11 "Care Meeting - Resident's weight down 7 lbs this week. Unable to get a reweight as the resident refusing to get out of bed most days..."</p> <p>* 12/30/11 "Spoke with [family member] about res order for Remron [sp]. Res [family member] stated 'every time we come in res is groggy and out of it,' stated they thought adding another antidepressant would 'make it worse.' Explained that med would be used for appetite as res had poor appetite and is losing weight. [Family member] stated 'well he could stand to lose a few pounds.' Stated she would discuss it with her family and call facility back."</p> <p>* 12/30/11 "[Family member] called back et stated the family does not want res on anymore antidepressant drugs."</p> <p>NOTE: Resident had diagnosis of mild mental</p>	F 320		
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F 320	<p>Continued From page 38</p> <p>retardation and cerebral palsy but did not have a court-appointed guardian. Family member was the durable power of attorney for health care if the resident was incapacitated or deemed by a court to be incompetent. The DON acknowledged to this surveyor they consulted the family but the resident was his own decision-maker. It was not clear why the resident was not consulted regarding treatment for his depression. It was also not clear why the family was consulted 7 weeks after dietary had made the recommendation for Remeron.</p> <p>* 1/4/12 "Resident refused meds on 1/1/12 at 1600 [4:00 pm], family and MD aware."</p> <p>The resident suffered weight loss as a result of his refusals as documented.</p> <p>The resident's weights were documented in a Weights and Vitals Summary as follows:</p> <ul style="list-style-type: none"> * 8/1/11 268.4 pounds * 9/16/11 263.4 pounds NOTE: 6 weeks in between weights * 10/28/11 245.6 pounds NOTE: 6 weeks in between weights and resident lost 17.8 pounds or 6.8%, which would be considered severe weight loss. * 11/12/11 246.4 pounds * 11/18/11 252.04 pounds * 11/26/11 254.0 pounds * 12/9/11 248.0 pounds * 12/16/11 250.4 pounds * 12/23/11 243.0 pounds NOTE: Loss of 7.4 pounds in one week, 3% in one week, 11 pounds in one month, 4.3% in one month. * 1/13/12 246.0 pounds <p>On 1/25/12, the Regional Dietary Manager stated the gaps in weight for the resident were due to his refusals to reweigh when weight loss was</p>	F 320		
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F 320	<p>Continued From page 39 documented.</p> <p>A quarterly Medical Nutrition Therapy Assessment, dated 9/2/11, documented the following:</p> <ul style="list-style-type: none"> * Meal intake: Breakfast - Refused, Lunch - Refused, Dinner - 81%, 27% average intake, 120 ml [milliliters] liquids per meal. * No between meal snacks, no supplements, no increased calories, protein, or fluid volume. * Admission weight - 284 pounds, weight as of 8/1/11 - 268.4 pounds * Current intakes inadequate to meet est [estimated] needs. Refuses meals often. Refuses fluids often. 3.8% weight loss in 30 days. Change of condition sent to MD [on] 8/3/11 to notify of wt [weight] loss. <p>NOTE: The resident's weight was identified in a Change of Condition Documentation form, dated 11/9/11, as 279 pounds as of July 1, 2011. This form also documented the resident as refusing meals and his intakes were inadequate to meet his estimated nutritional needs. Interventions listed were to order labs, schedule a family meeting, consider a medication change to Remeron, enhanced meals and snacks, and an updated food/preference interview. NOTE: The Food Preferences Interview, dated 12/1/11, documented no changes in likes or dislikes. An IPN, by the registered dietitian [RD], dated 11/18/11, documented "On 11/10, I spoke with [resident] re: [regarding] snacks to increase PO intake. Added yogurt to 2:00 [pm] snack and ice cream with 8:00 pm snack." On 12/8/11 was documented, "Per RD request to increase pro. [protein] added milk to banana snack." On 12/28/11, the RD documented, "...Resident continues to get snacks between meals. PO</p>	F 320		
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F 320	<p>Continued From page 40</p> <p>intakes R [refusals at breakfast]/ 20 [percent of lunch consumed]/ 52 [percent of dinner consumed]. Resident accepts snacks."</p> <p>Meal Monitors from August 2011 to January 23, 2012 luncheon meal for Resident #6 documented the following percentages of refusals:</p> <ul style="list-style-type: none"> * Breakfast-food refused 79% and fluids 84% * Lunch-food refused 55% and fluids 68% * Dinner-food refused 17% and fluids 37% * Bedtime snacks-refused 52% <p>On 11/14/11, lab values for the resident were as follows:</p> <ul style="list-style-type: none"> * Total Protein 6.2 grams/deciliter [g/dl]. Normal values are 6.3-82. LOW * Albumin 3.8 g/dl. Normal values are 3.5-5.0. <p>On 12/29/11, lab values for the resident were as follows:</p> <ul style="list-style-type: none"> * Total Protein 6.2 g/dl. Normal values are 6.3-8.2. LOW * Albumin 3.3 g/dl. Normal values are 3.5-5.0. LOW <p>There was no documentation the Interdisciplinary Team identified an underlying cause to the resident's weight loss, only fortifying meals the resident was not eating and attempting to add an antidepressant medication not labeled by the Food and Drug Administration for use as an appetite stimulant. Although the resident's weight did not continue to decrease, the underlying cause was not investigated nor did there appear to be any discussion as to his refusals to be weighed or reweighed and the impact these would have on evaluation of a resident already displaying frequent refusals of intakes, resulting in weight loss. The resident's likes and dislikes</p>	F 320			

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F 320	<p>Continued From page 41</p> <p>were reviewed on 12/1/11, after the resident had been in a decline for months and he continued to refuse meals and fluids after that interview. There was no documentation of a need to develop a new care plan and interventions for his refusals and to find a root cause for these refusals.</p> <p>The resident's Care Plan for Depression included the following interventions:</p> <ol style="list-style-type: none"> 1. Observe and report any s/s [signs and symptoms of] depression indicators, such as a decreased appetite, weight loss, increased insomnia, fatigue, feelings of worthlessness, decreased concentration, and thought of death. Date initiated: 12/5/2010 2. Note and record any behaviors that [resident] displays. Date initiated 12/5/2010 <p>The resident's quarterly Nursing Assessment, dated 12/21/11, documented "none of the above" in the section on Mood and Behavior. This section of the assessment asked if the resident appeared tearful, fearful, agitated, anxious, withdrawn, sad, or anger regarding placement. Under behavioral symptoms was documented the resident resists care.</p> <p>On 1/24/12 at 9:15 am, LN #4 was interviewed regarding the resident's refusals and isolation. LN #4 stated she had only worked at the facility for one month but to her knowledge, she had only witnessed Resident #6 out of bed once during that time.</p> <p>On 1/24/12 at 12:20 pm, CNA #3 was interviewed regarding Resident #6's refusals of care and isolation. CNA #3 stated she had worked at the facility for 11 months and that Resident #6's</p>	F 320		
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F 320	<p>Continued From page 42</p> <p>decline began after his birthday in June. She stated one of the resident's family members had remarked to the resident that they were surprised he had lived as long as he had. CNA #3 stated Resident #6 had repeated this to her and that he appeared to be upset by this remark. She stated since that time, he has refused to get out of bed, refused meals, and refused to participate in activities.</p> <p>Social Services notes documented no issues with refusals of cares or meals in a quarterly note dated 9/2/11. In a note dated 12/22/11, the LSW documented, "...He has been staying in his room for the major part of the day despite staff efforts to get him out of bed to socialize with other residents or clean his bed...[Resident] has been reported to be depressed and crying in his room at times...Attempts are being made by staff and others to assist [Resident] in becoming more social in attempts to help with his seclusion correction. SSD [Social Services Director] will continue to follow as needed." NOTE: The resident's quarterly MDS assessment, dated 12/21/11 documented no refusals of care. According to the MDS Coordinator, this section would have been completed by the LSW.</p> <p>The LSW [SSD] was interviewed on 1/25/12 at 9:20 am. The LSW stated he had been employed at the facility approximately seven months. The LSW stated he felt that Resident #6 was in a cycle, that he occasionally would go through periods of refusals. It was not clear how the LSW had established this as a cycle since he had only been employed at the facility for seven months. The LSW stated he felt the resident "appears that he is just lonely." The LSW stated he had spoken</p>	F 320		
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F 320	Continued From page 43 with the POA who was a family member, and that they had not been able to visit for quite some time due to the road conditions. The LSW said he talked with the POA about the resident going to Senior Counseling services on 1/24/12. The LSW was informed the POA was not in effect as the resident was his own decision maker and he acknowledged the resident was not incapacitated and it was not up to the family for approval of counseling services. The LSW did state he had spoken with the resident on 1/24/12 as well, at approximately 4:00 pm, and he was agreeable to attending Senior Counseling services. The LSW was asked why he had not made a referral for the resident to receive counseling services prior to yesterday. He stated he had not been aware of the resident's condition. The LSW was asked if he had any knowledge of whether the resident had ever had any psychiatric evaluations before, as he was on an antidepressant and an antipsychotic medication. The LSW stated he was not aware of any psychiatric evaluations for Resident #6. The LSW was asked why the behavior monitoring sheets for Resident #6 did not indicate his isolation, withdrawal, and refusal of cares and meals, in comparison to reported, documented, and observed behaviors for the resident. The LSW stated he did not know why these behaviors were not being documented. The LSW was asked if he knew when the resident had left his room last and he stated he did not know. The LSW was informed of the statement made by a family member regarding the resident living this long and the LSW stated he was unaware of the statement or the impact it might have had on the resident's mood and behaviors. The LSW was asked what he believed to be clinical indicators of depression and he stated	F 320		
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F 320	<p>Continued From page 44</p> <p>tearfulness, self-isolation, and lack of interest in anything. He was asked if somnolence could be an indicator and he stated yes, it could. The LSW was asked if weight loss could be a clinical indicator of depression and he affirmed, yes, it could and stated, "glad you said that." He stated they had a care plan meeting every Wednesday morning to discuss issues such as weight loss but that neither the physician nor the physician assistant attended those meetings. The LSW stated he noticed when he talked with Resident #6 about attending Senior Counseling that the resident's mucous membranes were very dry and offered him a drink. He also stated he felt they [the facility staff] need education on a resident's right to refuse versus behaviors that are detrimental to a resident's health.</p> <p>Activity records for Resident #6 were reviewed from August 2011 to January 2012. These indicated the resident last participated in an activity outside of his room on 8/22/11, although the Activities Director did not think this was correct. An Interdisciplinary Progress Note, dated 12/24/11, completed by the Activities Director, documented, "He is spending most of his time in bed now. He is refusing to get up for activities..." In an interview with the Activities Director on 1/25/12 at 10:20 am, she stated the resident refused to eat in the dining room and that he began "going downhill" somewhere in July and August of 2011. The Activities Director stated she did one-to-one visits with the resident in his room and brought music activities to his room. She stated she did not believe he had left his room for an activity since July. She stated he "just lays there, not responsive." She stated the resident had reported to her that his hip hurt when he was</p>	F 320		
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CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135107	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/26/2012
NAME OF PROVIDER OR SUPPLIER IDAHO FALLS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3111 CHANNING WAY IDAHO FALLS, ID 83404		
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F 320	<p>Continued From page 45</p> <p>out of bed and in the chair and that she had reported this issue to nursing. She stated she has been very concerned about the resident and in the last few weeks, he has isolated even more, staying in his room with the lights and television off. She stated the issue had been discussed at the weekly Care Plan meetings and that the facility was aware he was declining and that she reported she felt the resident was severely depressed. The Activities Director also acknowledged the resident's room had a very strong smell of urine. She stated she had worked at the facility for 23 years and did not think the resident was admitted with a diagnosis of depression.</p> <p>The physician progress notes documented the following: * 10/25/11 "The patient is doing well. No complaints. No changes. Behavior is okay. Participates." by the physician. NOTE: It is unclear what documents the physician reviewed in making this notation as multiple refusals for showers and meals were present in the medical record, as well as no participation in activities. * 11/11/11 "...His weight is down 12% since July. He has been refusing some of his meals. Dietary has consulted. His intakes have been inadequate for his established needs...He says he does not feel hungry...They are going to have a family meeting and consider changing to Remeron. They are going to put him on some enhanced meals with a special nutrition program..." noted by the physician assistant. NOTE: Again, no mention of his other behaviors of self-isolation, withdrawal and refusal of showers and activities by the physician assistant. The review of the physician progress notes</p>	F 320			

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F 320	<p>Continued From page 46</p> <p>showed that neither the physician nor the physician assistant were addressing all of the behaviors exhibited by the resident, refusal of meals resulting in weight loss only being one of them.</p> <p>The resident was interviewed on 1/25/12 at 1:45 p.m. When asked about his appetite, he stated he didn't always like to get up and leave his room, and would rather eat in the room. He pointed to a picture of his mother and father on the wall, and smiled when telling of the ranch and bringing hay in with the tractor. He began to tear up, and spoke of his mother having a heart attack and passing away. He cried for a few minutes, and could not respond to other questions about his well-being and preferences. It was obvious he still experienced sadness at the loss of his parents. After a few moments, he collected himself and smiled when thanked for allowing the opportunity to speak with him.</p> <p>The resident suffered worsening symptoms of depression and the facility failed to identify these symptoms or intervene to keep the resident from being harmed. The facility failed to properly document or determine the underlying causes of his behaviors. The resident displayed a persistent depressed mood manifested by social withdrawal and disengagement, tearfulness, crying, loss of interest in activities, and apathy, also manifested by weight loss, skin rash and excoriation, and diminished appetite. These resulted in harm to the resident. The facility failed to review or evaluate the resident's care plan for depression, in spite of their own documentation of his psychosocial decline.</p>	F 320		
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F 320	Continued From page 47 The Administrator, DON, and other clinical consultants were informed of this issue on 1/26/12 at 11:00 am. No further information was received from the facility on this issue.	F 320	F323	
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, facility policy review and staff interview, it was determined that the facility failed to put effective interventions in place and/or revise care plans to increase supervision as needed to prevent falls. This was true for 2 of 15 (#s 14 and 8) sampled residents identified as being at increased risk for falls or repeated falls. This resulted in harm when Resident #14 experienced pain and loss of function as a result of multiple fractures, and in the potential for harm to Resident #8 who experienced repeated falls. Findings include: 1. Resident #14 was admitted to the facility on 10/20/11 and readmitted on 1/24/12 with diagnoses of aftercare healing of traumatic fracture to bone, dementia, atrial fibrillation, chronic pulmonary and heart disease and depression.	F 323	1. Resident #8's fall care plan was updated by the IDT on or before 2/22/12 to ensure the resident's care plan reflects documentation of the increased supervision provided. Resident 8#'s falls history was reevaluated by the interdisciplinary team on or before 3/20/12 to further review causative factors. Resident #14 discharged from the facility on 2/21/12. 2. Residents who have been evaluated at risk for falls are at risk to potentially be affected. A review of residents with a history of falls will be completed on or before 4/02/12 by the IDT. Factors to be evaluated include; cognitive status and the ability to follow direction, medication regimens have been considered as potential contributory factor, sleep patterns, toileting schedules and activity patterns in addition to other possible factors. A review of physician orders, the past history of the resident, care plan interventions will be considered as part of the review. Based upon the IDT review, discussion and recommendations, the physician will be notified if there is a need to obtain new orders, the care plan will be updated accordingly. The resident and responsible party will be contacted and findings and recommendations will be reviewed.	

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F 323	<p>Continued From page 48</p> <p>Resident #14's 10/27/11 admission MDS assessment documented the resident had severe cognitive impairment with a score of 6 on the Brief Interview for Mental Status [BIMS] assessment. The resident required extensive staff assistance with transfers, dressing and hygiene and supervision when walking. The resident was assessed as having balance difficulty, requiring human assistance to stabilize when moving from a seated position to standing and from surface to surface, (bed to chair or wheelchair). The resident was also assessed as frequently incontinent of urine and occasionally incontinent of bowel. The resident was documented as having had a fall with fracture prior to admission and a non-injury fall since admission.</p> <p>A hospital record, dated 10/17/11, documented the resident had sustained a mechanical fall with fracture of the right humeral head and neck. The resident was not considered to be a good surgical candidate, and the arm was placed in a sling. The resident was admitted to the facility for rehabilitation with physical and occupational therapy.</p> <p>Resident #14's Care Plan identified the risk for falls related to unsteady gait, pain, generalized weakness, history of falls and daily psychotropic medication use. The goal was identified as, "No significant injury related to a fall." Interventions were listed and dated as initiated on 10/20/11: *Pressure alarms to bed and wheelchair *1/4 side rails up x 2 as enablers to aid with bed mobility *Assist resident getting in and out of bed with x 1 assistance</p>	F 323	<p>Tracking and trending of the last three months of falls was reviewed and changes were made from the PI Committees evaluation on or before 4/02/12 by the IDT.</p> <p>3. The Interdisciplinary team were re-educated by the Director Nursing of Services/designee on or before 4/2/12 related to effective and realistic fall interventions and revision of care plans to include documentation of provided increased supervision related to fall prevention. The education will also focus on realizing the residents cognitive status while determining the intervention to be implemented.</p> <p>Re-education on shift to shift reporting and change of condition assessment was provided to the IDT was provided by the Director of Nursing on or before 4/02/12.</p> <p>Root Cause Analysis training was completed with IDT by the Administrator on or before 4/02/12.</p> <p>A Root Cause Analysis worksheet will be completed on each fall by the interdisciplinary team beginning 3/19/12 to insure that the causes of the incident is identified and effective interventions are implemented and resources are deployed as needed for each fall.</p>		

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F 323	<p>Continued From page 49</p> <ul style="list-style-type: none"> *Encourage resident to use handrails or assistive devices properly *Have commonly used articles within easy reach *Remind resident to use call light prior to ambulating or transfer *When resident is in bed, place all necessary personal items within reach *PT [physical therapy] evaluation *Place call light within easy reach of resident *Ensure environment is free of clutter *Encourage resident to transfer and change position slowly *Encourage resident to communicate needs/ask for assistance. <p>NOTE: Based on the resident's level of cognitive impairment, it was not clear how encouraging and reminding the resident to seek assistance was of benefit to prevent falls.</p> <p>A 10/25/11 Incident /Accident report documented the resident experienced a fall at 3:30 a.m. The report described the bed alarm as sounding as staff was entering the room. The resident reportedly went from standing to her knees, catching her right arm on a chair next to her bed. The resident was described as being confused, trying to get to the bathroom unassisted. The resident reportedly told staff she got "all turned around" and lost her balance. The recommendation to prevent further falls was listed as "Toilet resident q2hs [every 2 hours] and PRN [as needed]."</p> <p>The resident's Care Plan was updated on 10/25/11 to include "Offer to toilet [Resident #14] q2hs and PRN. In addition, the Care Plan interventions added "Stargazer Program" on</p>	F 323	<p>An additional Licensed Nurse will be added to the facility staffing from 6:00pm to 6:00am Monday through Friday and 24 hours per day on the weekends once the recruiting and hiring process can be completed. This additional resource will provide increased supervision of fall interventions and will be responsible for monitoring staff activities and assisting with continued education on this shift.</p> <p>An Assistant Director of Nursing (RN) position will also be added to the Nursing Management Team once the recruiting and hiring process can be completed. The focus of this position will be to assist the Director of Nursing in ensuring that clinical systems that are positively impacting the care delivered to the residents.</p>		

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F 323	<p>Continued From page 50</p> <p>10/25/11. On 11/1/11 the Care Plan interventions were updated to include non slip footwear, reinforce the need to call for assistance and evaluate effectiveness and monitor side effects of psychotropic drugs daily.</p> <p>Interdisciplinary Progress Notes (IPNs), dated 10/26/11 at 6:00 p.m. documented the resident attempted to self transfer three times, and had been reminded to ask for assistance. The note also stated the resident had been taken to the emergency room for an x-ray. A note on 10/27/11 at 11:15 a.m. documented the resident had the x-ray to recheck the status of the right arm subsequent to the 10/25/11 fall.</p> <p>An 11/3/11 8:20 a.m. IPN documented the resident had not rested well and had complained of right shoulder pain at 11:30 p.m. and 3:30 a.m. The note also stated the resident was confused, and sat on the edge of the bed and fell asleep. CNAs were reportedly instructed "to watch her closely q[every] time they walked the hall."</p> <p>An 11/7/11 2:20 p.m. IPN documented the resident was very confused, asking for her mother and brother. The resident was reportedly getting off the bed, and the RN ordered a CNA to stay in the room with her. The family was called to help give the resident Lorazepam for anxiety, which the resident reportedly still refused. The notes did not document the length of time the CNA was assigned to stay with the resident.</p> <p>An 11/9/11 Incident /Accident report documented the resident experienced a fall at 1:00 a.m. The report stated the resident was found lying on her back on the floor in her room. The resident</p>	F 323	<p>4. Starting the week of 04/02/12 audits will be completed by the IDT as assigned by the administrator of residents with history of falls four times weekly for two months and two times weekly for four months to ensure fall interventions are clearly documented on the fall care plan and that the interventions listed are actualized while providing care. A summary of the audits will be submitted to the PI Committee for review and recommendations monthly for six months to ensure that systematic compliance and employee education has been maintained. Ongoing education will be provided to the facility staff and IDT on fall interventions by the Director of Nursing and Administrator quarterly and during orientation for newly hired employees. The PI Committee will re-evaluate the need for further monitoring and education after six months. The Director of Nursing Services and Administrator will be responsible for compliance.</p> <p>Date of Compliance: 4/04/12</p>	
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F 323	<p>Continued From page 51</p> <p>reportedly stated she hit her head on the floor and complained of head pain. The resident was assisted to her wheelchair and stated she was going to pass out. The resident's pupils were assessed and were found to be nonresponsive to light. The resident stopped answering questions and was unresponsive to stimuli. According to the report, family was contacted and they requested the resident be transported to the emergency room for evaluation.</p> <p>The report documented the alarm in place was on and sounding at the time of the incident. Recommendations to prevent further falls were listed as: bed in lowest position, 1/4 side rails up, alarm in bed, pressure alarm to wheelchair, Stargazer program, anti-tippers to wheelchair and wedge cushion. Toilet every 2 hours. The Root Cause Conclusion was "Pt[patient] confused and trys [sic] to self transfer."</p> <p>The Hospital emergency room report, dated 11/9/11, documented the resident complained of head and right hip pain. The clinical impression was "Multiple contusions to the head and right hip." Ice to the areas and elevation were ordered.</p> <p>The Care Plan was updated on 11/9/11 to include the interventions of anti-tippers to wheelchair and wedge cushion to wheelchair.</p> <p>Note: The Care Plan was updated to include wheelchair adaptations to prevent falls, however, the resident fell getting up from the bed on both 10/25/11 and 11/9/11, and it was not clear how the wheelchair adaptations would impact fall prevention from the bed. Of the recommended interventions noted on the incident report, all were</p>	F 323		
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F 323	<p>Continued From page 52</p> <p>already in place with the exception of "bed in lowest position."</p> <p>IPNs documented: 11/10/11 1:30 a.m. Resident assisted back to bed multiple times. 11/10/11 7:30 p.m. Resident confused, attempted to self transfer multiple times. 11/11/11 3:00 a.m. Resident was very agitated and confused, up a few times and assisted back to bed.</p> <p>An 11/15/11 Incident /Accident report documented the resident experienced a fall at 9:30 p.m. The report stated the resident was "under close supervision" in her wheelchair in hall 4 while the nurse was passing medications. The resident was observed to "scoot " to the edge of her seat and was repositioned by staff back into the seat. Five minutes later the resident reportedly "scooted out of the wheelchair" and landed on her bottom on the floor.</p> <p>Recommendations to prevent further falls included a new order for Risperdone, pressure alarms to wheelchair and bed, bed in lowest position, gait belt on so that when the resident decides to get up and walk staff can help her, Stargazer program and close supervision. The Care Plan did, however, include an 11/15/11 initiation of the use of a self-releasing alarmed seat belt.</p> <p>NOTE: The resident's Care Plan was not updated to include use of the gait belt or close supervision. The level and duration of supervision was not documented in the resident's record.</p> <p>IPNs documented:</p>	F 323		
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F 323	<p>Continued From page 53</p> <p>11/15/11 6:45 a.m. Resident extremely confused trying to walk into other resident's rooms. Refusing help from CNAs and nurse. Continued to be agitated and was helped back to bed many times.</p> <p>11/16/11 7:30 a.m. "Checked on pt all night frequently."</p> <p>11/16/11 7:30 p.m. Resident repeatedly attempting self transfers, requires constant supervision. A "6x6" purple bruise noted to mid-back from recent fall.</p> <p>11/17/11 8:00 p.m. Resident had "multiple bruises" to left and right lower extremities related to the fall.</p> <p>An 11/17/11 Incident /Accident report documented the resident experienced a fall at 10:00 a.m. while in physical therapy. The report stated the resident was assisted back into her wheelchair with her feet positioned in the foot rests. The therapist went across the room to assist another resident, and Resident #14 stood up and fell to the floor.</p> <p>Recommendations to prevent further falls were documented as Therapy staff monitoring the resident closely while in therapy and when finished they were to return the resident to nursing staff on the hall. The Narrative conclusion of root cause was, "The resident has dementia and forgets that she is unable to transfer herself without assistance." The report did not include information on whether or not the self releasing seat belt was in place at the time of the fall.</p> <p>The Care Plan was updated on 11/18/11 to include Therapy staff monitoring the resident closely while in therapy and when finished they</p>	F 323			

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F 323	<p>Continued From page 54</p> <p>were to return the resident to nursing staff on the hall.</p> <p>From 11/18/11 through 1/19/12 daily IPNs documented the resident was alert and confused with episodes of agitation.</p> <p>A 1/20/12 3:00 a.m. IPN entry stated the resident was sleeping, continued on Levaquin for a urinary tract infection. The entry was the first mention of the infection in the resident's notes.</p> <p>A 1/21/12 Incident /Accident report documented the resident experienced a fall at 3:45 p.m. The report stated the resident was found on the floor by staff responding to the alarm. The resident complained of left wrist and left hip/back pain. The resident was transported to the hospital for evaluation and treatment. The Narrative conclusion of root cause was, "[Resident #14] has dementia and does not always use her call light, she has a bed alarm to alert staff of any unassisted transfer attempt. The alarm was sounding - staff entered the room and the resident was found on the floor." Recommendations to prevent further falls was "place scoop mattress on bed - resident was admitted to the hospital and we will have the scoop mattress on the bed when she returns."</p> <p>The scoop mattress was added to the Care Plan on 1/25/12.</p> <p>The 1/21/12 hospital History and Physical report stated the resident was evaluated in the emergency room and was found to have thoracic 12 and lumbar 1 fractures and a left radius fracture due to the fall. The resident was</p>	F 323		
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F 323	<p>Continued From page 55</p> <p>reportedly referred to a surgeon for repair of the wrist fracture.</p> <p>Resident #14's Care Plan, dated 1/25/12, included new focus areas: "Vertebral fractures r/t [related to] fall requires use of brace S/P [status post] vertebroplasty" and "Orthopedic aftercare secondary to wrist and vertebral fractures..."</p> <p>A 1/24/12 7:30 p.m. IPN documented the resident had been readmitted to the facility with a cast on the left wrist due to fracture. The note also stated the dressing was removed from the site of the vertebroplasty.</p> <p>A 1/25/12 4:30 a.m. IPN stated the resident was agitated most of the night and continually got in and out of bed.</p> <p>The DON and clinical consultants were interviewed on 1/25/12 at 3:45 p.m. and asked about Resident #14's level of supervision. It was observed that the resident's room was closest to the nurses' station on 1/22/12. The DON stated it was not on the Care Plan, but it was for increased supervision. The DON further stated that in response to the 11/15/11 fall, nurses were parking the medication cart close to the resident's door for increased observation, even at night. The DON confirmed the level and frequency of supervision was not described in the Care Plan.</p> <p>When asked about the resident's agitation and its impact on her self-transfers and falls, the DON stated that instead of placing the resident on 1-1 staff supervision, a family member was called in to calm the resident down, and that due to a history of sexual assault, staff were not called in</p>	F 323			

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F 323	<p>Continued From page 56 to the resident's room.</p> <p>NOTE: At 4:15 p.m. on 1/25/12 the DON clarified the resident's history as having been in an abusive relationship rather than the victim of sexual assault by a stranger. Resident #14's 1/16/12 Care Plan identified the focus area of a history of physical, emotional and sexual abuse and the potential for her to make statements related to her history. The interventions included the assignment of female caregivers only; however, the care plan did not include any instructions to staff on calling family in when the resident became agitated. The resident's record did not contain information on rationale for not using facility staff for 1-1 supervision.</p> <p>A packet of documents was provided to the surveyor on 1/26/12 at 10:45 a.m. prior to the exit conference. The documents included a copy of the fall Care Plan with the following entries handwritten on the bottom of the interventions column: "Position medication cart outside of [Resident #14's] room for increased supervision. Staff to call [family member name and telephone number] when [Resident #14] is anxious or agitated. Provide 1-1 staff until [family member] arrives." On the second page of the Care Plan were, "When 1-1 staff is needed give [Resident #14] enough space as not to agitate her more yet stay close enough to keep her safe. Place [Resident #14] my (sic) nursing med cart (in her wheelchair) during times of anxiety or agitation if appropriate. [Resident #14] is in room 401 to be close to the nursing station for increased supervision." The entries were undated and unsigned/uninitialed and not present on the copies present in the record during the survey.</p>	F 323		
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F 323	<p>Continued From page 57</p> <p>Resident #14 was admitted to the facility for rehabilitation after a fall with fracture in the home setting. Within 5 days of admission, the resident sustained a fall from bed which required emergency room evaluation for possible reinjury to the fractured shoulder. Fifteen days later, a second fall from bed resulted in a head injury and a period of unresponsiveness with another trip to the emergency room for evaluation. On 1/21/12 the resident again fell from bed and sustained fractures to the spine and wrist. Alarms to the bed were operational, but ineffective at preventing the falls and injuries. The scoop mattress to the bed was not put in place until after the final fall with fracture. In addition, the Care Plan failed to include increased supervision interventions in response to even the final fall with fractures, which placed the resident at continued risk for falls.</p> <p>2. Resident #8 was admitted to the facility on 6/7/11 with diagnoses of dementia with conditions listed elsewhere without behavior disturbances, congestive heart failure and after care for traumatic fracture of the hip.</p> <p>The resident's most recent quarterly MDS assessment, dated 12/15/11, documented the resident:</p> <ul style="list-style-type: none"> * Had severe cognitive impairment, * Required extensive assistance for transfer, dressing, personal hygiene and bathing, * Was incontinent of bowel and bladder. <p>The resident's admission MDS assessment, dated 6/14/11, documented that the resident had no falls prior to admission.</p>	F 323		
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F 323	<p>Continued From page 58</p> <p>Resident #8's care plan for falls, dated 6/7/11, documented,"Risk of falls related to: decreased balance and having a history of falls." The interventions were:</p> <ul style="list-style-type: none"> ** Call bell within reach. [initiated 6/20/11] * Hi/low bed in lowest position. [initiated 8/9/11] * Pressure alarms to the bed to alert staff of any unassisted transfer attempts. [initiated 6/20/11] * Have the activity department involve [Resident #8] in activities as he will allow. [initiated 7/17/11] * Offer [Resident #8] a book, the paper, or magazine to read to help divert his attention. [initiated 7/17/11] * Offer to toilet [Resident #8] every 2 hours. [initiated 7/15/11] * Therapies to treat as ordered. [initiated 6/20/11] * 1/4 side rails x 2 to assist with bed mobility and transfers. [initiated 6/20/11]" <p>Resident #8 was admitted to the facility after surgery to repair a fractured right hip. Since August 2011 [6 months] the resident had fallen 8 times. On two occasions the resident had to be taken to the emergency room for x-rays of the right hip related to possibility of a fracture or damage to the hardware used to fix the original fracture.</p> <p>On 8/28/11 at 7:40 p.m. an incident and accident [I&A] documented an aide observed the resident stand then go to the floor. The seatbelt was buckled behind the resident.</p> <p>Care plan intervention added:</p> <ul style="list-style-type: none"> ** Self release alarm belt to wheelchair, release [every] 2 hours for positioning and toileting needs. [initiated 9/2/11] [note: this was discontinued on 	F 323			

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F 323	<p>Continued From page 59 1/12/12]</p> <p>* When resident is up in his wheelchair please keep him in the hallway for increased supervision. [initiated 8/28/11]"</p> <p>On 9/27/11 at 7:40 p.m. an I&A documented the resident was in the TV room and was observed to slide out of the wheelchair to the floor.</p> <p>Care Plan intervention added: ** [Resident #8] often will undo his alarming seatbelt alarm and then do it up behind him to stop the alarming sound. Staff education to check on [Resident #8's] alarm to make sure that it is in place and functioning. [initiated 9/27/11] [note: this was discontinued on 1/12/12]"</p> <p>On 10/11/11 at 7:00 p.m. a "Change of Condition Documentation" form documented the resident "Alarm sounded. This nurse observed resident sitting on his right side on floor by bed with bed alarm sounding. Resident states 'I fell out of bed.' Resident has small bruise to left forehead and small bruises to right forehead. Resident unable to extend right leg all the way. Sent to ER [emergency room] for further evaluation. The resident's right hip was x-rayed and no damage or fracture was found.</p> <p>Care Plan intervention added: ** Resident to be last down at night and keep near nurses station for increased supervision. [initiated 10/11/11] * Move [Resident #8] to room 104 to be closer to the nursing station for increased supervision. [initiated 10/11/11] * Left side of the bed against the wall. [initiated 10/11/11]"</p>	F 323			

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F 323	<p>Continued From page 60</p> <p>On 11/15/11 at 3:40 a.m. a "Change of Condition Documentation" form documented the "Resident's bed alarm sounded. CNA went in and found him on the floor. He has a cut to the right side of his head and a skin tear on his right elbow. Intervention have maintenance install a motion detector on the wall."</p> <p>Care Plan intervention added: ** Motion sensor to the side of the bed to alert of any unassisted transfer attempts. [initiated 11/15/11]"</p> <p>On 11/26/11 at 1:00 pm. an I&A documented the resident was in the TV lounge and was found on the floor. The self release seatbelt was undone. The Interdisciplinary Progress notes document the resident sustained a "skin tear to the left elbow" from the fall.</p> <p>Care Plan Intervention added: ** Nursing staff education to ensure that alarms are in place and batteries are working. [initiated 11/26/11]"</p> <p>On 12/13/11 at 8:30 p.m. a "Change of Condition Documentation" form documented the "Resident was found on the floor down by the lunch room his lap belt wasn't on or done up. No injuries noted. Teachable moment remember to connect his lap belt after he's done eating before he leaves the lunch room."</p> <p>Care plan intervention added: ** Lower the back of the wheelchair to improve [Resident #8's] posture." [initiated 12/13/11]</p>	F 323		
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F 323	<p>Continued From page 61</p> <p>An x-ray of the right hip was done on 12/21/11. The resident was having some weakness on the right side after the fall on 12/13/11. The x-ray was negative for fractures or changes to the right hip.</p> <p>On 1/11/12 at 11:30 a.m. a "Change of Condition Documentation" form documented the "Resident was in physical therapy sitting in wheelchair.... He pushed his feet on the floor and tipped backwards in wheelchair...."</p> <p>Care plan intervention added: ** Anti-tip bars placed on back of wheelchair. [initiated 1/11/12] * Velcro seat belt in wheelchair [initiated 1/12/12] * Alarming pressure pad in wheelchair to alert staff of unassisted transfer attempt. [initiated 1/12/12]"</p> <p>On 1/21/12 at 9:00 p.m. a "Change of Condition Documentation" form documented the "Resident's alarms were going off. Hall nurse entered room to find resident in his knees. Resident stated he needed to go to the bathroom Resident stated he did not hit his head, he did receive a skin tear to right ring finger and pinky finger...."</p> <p>On 1/24/12 at 9:00 a.m. Resident #8 was in the TV room waiting for the activity to start. The activity was Price is Right on the TV. The residents were left in the room unsupervised to watch the program on TV. From 9:00 a.m. until 9:10 a.m. Resident #8 was observed to be leaning forward in the wheelchair and he made multiple attempts to stand up out of the wheelchair. He had not succeeded when at 9:10 a.m. a CNA brought him to his room and put the</p>	F 323		
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F 323	Continued From page 62 resident to bed. The facility failed to increase supervision of the resident. The resident: * would undo the seatbelt and stand, * would get out of bed and fall before staff got to him even with the alarms in place. * was taken to bed rather than supervised during an activity, * had multiple falls which resulted in skin tears and hip pain requiring x-rays. Supervision had not been increased- only the number of alarms to summon staff after a fall. The DON was interviewed 1/24/12 at 3:00 p.m. about the falls. The resident had an alarm seatbelt but he used to take it off and buckle it behind him. The belt was changed on 1/12/12 to a Velcro belt. The resident had a pressure alarm in the seat of the chair, bed alarms and environmental alarms in the room. No further information was obtained.	F 323		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.	F 328	F328 1. Resident # 2's O2 tank was changed and turned on to the current setting per physician's order by nursing staff on 1/22/12. Resident #2's respiratory status was assessed by the Licensed Nurse with no change in condition noted. 2. An audit of residents receiving oxygen was completed by the Director of Nursing Services on or before 2/27/12 to ensure resident are receiving O2 per physician's order. No additional occurrences were noted.	

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F 328	<p>Continued From page 63</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff and resident interview, it was determined the facility failed to ensure oxygen was administered as ordered by the physician for 1 of 5 sample residents receiving oxygen therapy, (#2). Findings include:</p> <p>Resident #2 was admitted to the facility on 12/15/09 with diagnoses of dementia, Parkinson's disease, diabetes mellitus and kidney failure.</p> <p>The resident's physician orders, recapitulation, for 1/12 included the order for oxygen at 2 liters per minute via nasal cannula.</p> <p>On 1/22/12 at 5:25 p.m. staff were observed bringing Resident #2 to the dining room for the evening meal. The resident had a portable oxygen tank on the back of the wheelchair, with tubing to the nasal cannula in her nose attached. The tank was observed to be in the "off" position, and when the strap was lifted to register the amount of oxygen in the tank, it registered empty. The resident was asked at that time if she was getting any oxygen through the cannula, and she answered, "I don't know, I thought so." Staff were informed of the situation and took steps to fill the tank.</p> <p>The DON was informed of the findings at 10:45 a.m. on 1/24/12. No further information was provided by the facility.</p>	F 328	<p>3. The Facility staff and IDT were re-educated by the Director of Nursing or SDC on or before 4/02/12 related to maintaining O2 levels in tanks and O2 settings are per physician's order.</p> <p>4. Starting the week of 04/02/12 audits will be completed by the IDT as assigned by the administrator four times weekly for two months, and two times weekly for four months to ensure resident are receiving O2 per physician's order. A summary of the audits will be submitted to the PI Committee for review and recommendations monthly for six months to ensure that systematic compliance and employee education has been maintained. Ongoing education will be provided to the facility staff and IDT on O2 delivery per physician's orders by the SDC quarterly. The PI Committee will re-evaluate the need for further monitoring and education after six months. The SDC will be responsible for compliance.</p> <p>Date of Compliance: 4/04/12</p>	
F 329 SS=D	<p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from</p>	F 329		

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F 329	<p>Continued From page 64</p> <p>unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on resident interview, record review, and staff interview, it was determined the facility failed to ensure residents received only those medications for which there existed clinical indications for their use and monitor the efficacy of medications. This was true for 1 of 13 residents (#4) sampled for medication regimens. Resident #4 received scheduled and PRN [as needed] medication for dizziness. The record failed to contain clinical justification for the use of the medication and the facility failed to monitor for</p>	F 329	<p>F329</p> <ol style="list-style-type: none"> 1. Resident #4's order for Meclazine was clarified on or before 2/22/12 by the licensed nurse. The order was received from the physician extender and transcribed accordingly by a licensed nurse. 2. An audit of residents with orders for Meclazine has been completed on or before 2/27/12 by the Director of Nursing Services to ensure clinical justification is in place for residents with this order. 3. The IDT was re-educated on or before 4/02/12 by the Pharmacy Consultant related to the need for clinical justification for the use of Meclazine. <p>The IDT will conduct medication reviews in the morning meetings. The review will include new admissions, new orders and order changes.</p>	
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F 329	<p>Continued From page 65 effectiveness. Findings include:</p> <p>Resident #4 was admitted to the facility on 2/5/01 and readmitted on 1/1/10 with diagnoses of congestive heart failure, obesity, hypertension and status post uterine and breast cancer.</p> <p>Physician Orders, recapitulation, dated 1/12, included the following medication orders:</p> <p>*Meclizine HCL 25 mg [milligrams] tablet by mouth at bedtime every day for vertigo. Start date 1/1/10.</p> <p>*Meclizine HCL (antivert) 25 mg by mouth prn every 4 hours for dizziness. Start date 1/1/10.</p> <p>An 11/8/11 Nursing Assessment documented the resident did not experience dizziness.</p> <p>The resident's 1/20/10 Care Plan did not document vertigo/dizziness as a problem.</p> <p>The Medication Administration Records for 12/11 and 1/12 were reviewed and no documentation of effectiveness or side effects of the Meclizine were present.</p> <p>Physician visit notes from 4/11 through 1/12 were reviewed. None of the notes included information on vertigo/dizziness or treatment with the Meclizine.</p> <p>The DON was interviewed on 1/24/12 at 9:15 and 11:00 a.m. and asked about the resident's treatment with Meclizine for dizziness. The DON stated the resident had experienced an episode of dizziness "some time ago," possibly in 5/11, in physical therapy. Documentation related to the</p>	F 329	<p>4. Starting the week of 04/02/12 audits will be completed by the Nurse Management Team four times weekly for two months, and two times weekly for four months to ensure residents with orders for medications requiring ongoing monitoring for effectiveness have a clinical justification for use. A summary of the audits will be submitted to the PI Committee for review and recommendations monthly for six months to ensure that systematic compliance and employee education has been maintained. Ongoing education will be provided to the Licensed Nurses and IDT on monitoring the effectiveness of medications and clinical justification of the medication by the Director of Nursing or SDC quarterly and during Licensed Nurse orientation for newly hired employees. The PI Committee will re-evaluate the need for further monitoring and education after six months. The Director of Nursing Services will be responsible for compliance.</p> <p>Date of Compliance: 4/04/12</p>	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135107	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/26/2012
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NAME OF PROVIDER OR SUPPLIER IDAHO FALLS CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3111 CHANNING WAY IDAHO FALLS, ID 83404
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F 329	Continued From page 66 episode and any other clinical indication for the medication was requested at that time. On 1/26/12 at 4:15 p.m. the DON reported that documentation of the episode of dizziness could not be located in the resident's records. No further information was provided by the facility.	F 329	F387	
F 387 SS=D	<p>483.40(c)(1)-(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT</p> <p>The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter.</p> <p>A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined there was no physician visit for a resident as required every 30 days for the first 90 days, with a physician required to make the initial visit and every other required 30 day visit in the first 90 days. This was true for 1 of 9 (#1) sampled residents. Findings included:</p> <p>Resident #1 was admitted to the facility on 10/20/11 with diagnoses that included acute renal failure, status post cholecystotomy, sick sinus syndrome, atrial fibrillation, cerebral vascular accident with left hemiparesis and hemiplegia, and a chronic non-healing wound in his right lower extremity.</p> <p>A review of Resident #1's physician visits</p>	F 387	<p>1. Resident #1 was discharged from the center on 1/29/12.</p> <p>2. An audit of residents admitted in the past 30 days was completed by the Health Information Manager on or before 2/22/12 to ensure physicians' visits are current as required.</p> <p>3. Re-education was provided to the IDT and Health Information Manager by the Administrator related to the requirements for physician's visits on or before 4/02/12.</p> <p>Calendars are given to the IDT weekly by the Health Information Manager beginning 3/26/12 with the residents last visit date highlighted to ensure appointments are scheduled with the attending physician in coordination with the facility staff.</p>	

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F 387	Continued From page 67 documented the physician made the initial visit on 10/25/11 but no subsequent visits were made by the physician. According to the regulations, a physician visit would have been required in December. The DON confirmed on 1/24/12 at 8:00 am that there was no physician visit documented for the resident in December. The Administrator, DON, and other clinical consultants were informed of this issue on 1/26/12 at 11:00 am. No further information regarding this matter was received from the facility.	F 387	4. Starting the week of 04/02/12 an audit will be completed by the Interdisciplinary team as assigned by the administrator four times weekly, for two months and two times weekly for four months to ensure resident physicians' visits remain current. A summary of the audits will be submitted to the PI Committee for review and recommendations monthly for six months to ensure that systematic compliance and employee education has been maintained. Ongoing education will be provided to the facility staff and IDT on the requirement of frequency of physician's visits by the Health Information Manager quarterly. The PI Committee will re-evaluate the need for further monitoring and education after six months. The Administrator will be responsible for compliance.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a	F 441	Date of Compliance: 4/04/12 F441 1. Resident #1's bedside commode was removed from the room on 1/24/12 by the Director of Nursing Services due to non-use. Clothing was removed from the floor on 1/24/12 by the Director of Nursing Services and sent to be laundered. 2. An audit of resident rooms were completed by the Director of Nursing Services/designee on or before 2/22/12 related to infection control to include linen on the floor and bedside commodes with interventions implemented as needed.	

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F 441	<p>Continued From page 68</p> <p>communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on a complaint from the general public, observation, and staff interview, it was determined the facility failed to maintain a sanitary environment and prevent the development and transmission of disease when a resident's pillow was placed on top of a bedside commode and clothing worn to and from wound and hyperbaric treatment were thrown on the floor. This was true for 1 of 9 (#1) sampled residents. Findings included:</p> <p>Resident #1 was admitted to the facility on 10/20/11 with diagnoses that included acute renal failure, status post cholecystotomy, sick sinus syndrome, atrial fibrillation, cerebral vascular accident with left hemiparesis and hemiplegia, and a chronic non-healing wound in his right lower extremity.</p> <p>a. Resident #1 was observed in his room on 1/23/12 at 7:10 am. A pillow was observed lying</p>	F 441	<p>3. Re-education was provided to IDT and facility staff related to infection control requirements to include the placement of pillows and storage of linen by the Director of Nursing Services or SDC on or before 4/02/12. The licensed nursing staff will be re-educated to the facility Infection Control protocols by the SDC on or before 4/2/12.</p> <p>4. Starting the week of 04/02/12 audits will be completed by the IDT as assigned by the administrator four times weekly for two months, and two times weekly for four months to ensure that infection control protocols are practiced by the facility staff. A summary of the audits will be submitted to the Infection Control Committee for review and recommendations monthly for six months to ensure that systematic compliance and employee education has been maintained. Ongoing education will be provided to the facility staff and IDT on acceptable infection control practices and standards by the SDC quarterly and during orientation for newly hired employees. The Infection Control Committee will re-evaluate the need for further monitoring and education after six months. The Director of Nursing Services will be responsible for compliance.</p> <p>Date of Compliance: 4/04/12</p>	
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F 441	<p>Continued From page 69</p> <p>on top of a bedside commode. This bedside commode was observed to have dried urine on the seat and inside the receptacle. CNA #3 was asked if the pillow was used for the resident. CNA #3 replied that the pillow was used for the resident and he used several pillows, one behind his head and one under his lower extremities. CNA #3 replied the pillow "shouldn't be on top of the toilet," and removed it from the room.</p> <p>The surveyor did not wait to see when the CNA might use the pillow for the resident. The surveyor could not wait until that event might occur for resident's health and safety.</p> <p>b. Resident #1 was diagnosed with MRSA [methicillin resistant staphylococcus aureus] in his right lower extremity wound on 11/22/11.</p> <p>Interdisciplinary Progress Notes for Resident #1 documented the resident had a draining wound to his right lower extremity, with dressing changes performed by the facility, from admission until 1/10/12.</p> <p>Physician Orders [recapitulation] for January 2012 documented, "Right lower shin ulcer: leave dressing dry, clean, and intact. Do not remove. Please ensure that the tubigrip has no wrinkles and remains covering the RLE from toes to knee..." dated 1/9/12.</p> <p>The resident's closet was observed to have dirty clothes on the floor of the closet. CNA #3 was interviewed on 1/24/12 at 8:45 am regarding this practice. CNA #3 stated the resident had worn these clothes to his wound and hyperbaric appointments, as well as in the facility. When</p>	F 441		
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F 441	<p>Continued From page 70</p> <p>asked if they used any type of bagging or linen hampers for dirty linens and clothes in the resident's room, CNA #3 stated they bagged them in garbage bags before leaving the room with them but that they took no special precautions with linens and clothes in the resident's room. The resident's clothes could come in contact with his wound dressings and possibly his wound and become contaminated. Even without the diagnosis of MRSA, linens should not be placed on the floor, clean or dirty.</p> <p>The Administrator, DON, and other clinical consultants were informed of these issues on 1/26/12 at 11:00 am. No further information was received from the facility.</p>	F 441			

**Addendum to the Idaho Falls Care and Rehabilitation Plan of Correction
Survey Exit Date January 26, 2012**

- The purpose of the Customer First Program is to provide a focus on customer service and promote communication and relationship building with the staff and residents to assist in ensuring that concerns are being communicated between residents, family members and center staff. The goal is to be able to respond to the customer's concern and identify a plan of action to address concerns. The concerns are reported to the administrator and when they rise to a level of a grievance, the grievance and concern process is implemented. Ambassadors (Specifically identified center staff) are assigned to a range of room numbers within the facility that they are responsible for. These Ambassadors make rounds throughout their workday utilizing tools that assist them in identifying concerns that residents and families may have. Residents who have cognitive impairments are also asked general questions such as; How are you today? What can I do for you? During these visits the Ambassador assesses the resident's room conditions and the appearance of the resident.

- F253
 - The maintenance director has quit without notice this week, which has required the re-education be completed by the administrator. The re-education will include utilizing the maintenance log/work orders to notify the department of physical plant needs.

- F323:
 - Please see Organizational Chart, ADON Job Description and RN Center Supervisor Job Descriptions (Attachments A, B, C,) on following pages. The RN Center Supervisors will be in place on 4/3/12. ADON interviews are underway.
 - Interviews are underway for these added RN management/supervisor positions. The ADON and RN Center Supervisor (6:00pm – 6:00am and weekend manager) will specifically have amongst other duties the responsibility of managing the Fall Program. They will work in conjunction with the IDT to assess, plan, implement and monitor care plan interventions that are put into place to reduce the likelihood of a fall. Their duties will also include teaching/training nursing assistants, licensed nurses and other center staff on identifying residents at risk for falls and implementing immediate interventions to prevent falls.

- F328:
 - The portable oxygen units will be checked by the licensed nurse to assure that the unit is turned on and has been filled to an adequate supply of liquid oxygen available for use once the resident has been switched from the concentrator to the portable unit. The time of this validation will be documented in the resident's treatment record. The treatment records will be audited in morning clinical meetings by a member of the nurse management team and/or the IDT. If incomplete records are found the resident will be assessed by an RN. The resident's physician will be notified should the assessment identify any change in condition.

- F329:
 - The consulting Pharmacist was informed of the intent of this citation and will assure that his/her medication reviews include identifying clinical justifications and reviewing supporting practitioner/physician documentation for medications. The Medical Director will review the pharmacy reports with the PI Committee during their monthly meeting. If needed, the Medical Director will intervene with other physicians/practitioners to assure that the residents' medical record shows clinical indication of the medication.
 - Another consulting pharmacist was brought into the facility on 3/29/12 to review the medication regimens in order to identify other residents who may be at risk for receiving medications without clinical indication.

- F387:
 - As needed and upon the request of the Administrator the Medical Director will contact and educate other attending physicians of the regulations outlined in F387. The Medical Director will also send a letter to all other attending physicians explaining the requirements of physician visits in a Skilled Nursing Facility.

- F441:
 - The licensed nurses and nursing assistants were reeducated on our policy and procedures for handling soiled linens of residents on contact precautions on or before 4/4/12 to include contaminated/soiled linen will be bagged at the point of use, and not sorted or pre-rinsing in the resident care area. No special precautions (i.e.: double bagging) or categorizing is recommended for linen originating in isolation rooms. Handle, transport, and process linen soiled with blood and body fluids in a manner that prevents exposures and contamination of clothing and the environment.
 - The proper handling of linens for residents on contact precautions will be added to the ongoing infection control audits at the intervals outlined in the POC.
 - This education will be provided to the nursing staff quarterly and will also be incorporated into the orientation for newly hired employees.

If you have any questions/concerns about the addendum to the original Plan of Correction please feel free to contact me at (208) 529-0067.

Sincerely,

Kelly Spiers
Administrator
Idaho Falls Care and Rehabilitation

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001300	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/26/2012
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C 000	16.03.02 INITIAL COMMENTS The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2. The following deficiencies were cited during the annual licensure survey and complaint investigation of your facility. The surveyors conducting the survey were: Lea Stoltz, QMRP, Team Coordinator Arnold Rosling, RN Madeleine Parmley, RN	C 000	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Idaho Falls Care & Rehabilitation Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."	
C 125	02.100,03,c,ix ix. Is treated with consideration, respect and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; This Rule is not met as evidenced by: Refer to F241 as it relates to resident grooming.	C 125	C125 Refer to the 2567 for the corrective action for F241	
C 132	02.100,04,a a. The administrator shall not accept or keep patients/residents for whom the appropriate care level and services are not provided, or for which the facility is not licensed except in an emergency. This Rule is not met as evidenced by: Please refer to F285 as it relates to PASRR requirements.	C 132	C132 Refer to the 2567 for the corrective action for F285	

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FACILITY STANDARDS

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

TITLE
Administrator

(X6) DATE

3-20-12

Bureau of Facility Standards

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C 159	Continued From page 1	C 159		
C 159	02.100,09 RECORD OF PTNT/RSDNT PERSONAL VALUABLES 09. Record of Patient's/Resident's Personal Valuables. An inventory and proper accounting shall be kept for all valuables entrusted to the facility for safekeeping. The status of the inventory shall be available to the patient/resident, his conservator, guardian, or representative for review upon request. This Rule is not met as evidenced by: Based on staff interview and record review, it was determined the facility failed to ensure residents belongings were properly inventoried upon admission. This was true for 2 of 15 (#s 1 and 9) sampled residents. Findings included: Residents #s 1 and 9 both had blank inventory sheets in their medical records. The DON was asked on 1/25/12 at 1:30 pm to provide any further documentation that these residents	C 159	C159 1. Residents #1 had his inventory sheets completed by the nursing staff on 1/25/12 Resident #9 had his inventory sheets completed by the nursing staff on 1/25/12 2. An audit of residents' inventory sheets was completed by the Health Information Manager on or before 2/28/12 for completion 3. Re-education has been provided to nursing staff on or before 2/28/12 by the Director of Nursing/Designee related to the need to complete inventory sheets. 4. Starting the week of 02/28/12 audits will be completed by the Director of Nursing/designee weekly for 1 month and monthly for 2 months to ensure inventory sheets are completed. A report will submitted to the Performance Improvement Committee monthly for 3 months. The Director of Nursing Services will be responsible for monitoring and follow up. Date of Compliance: 3/1/12	
C 356	02.108,06,b,iv iv. Facilities used to collect, transport, and store soiled linen shall be stored in separate, ventilated areas and shall not be permitted to accumulate in the	C 356	C356 Refer to the 2567 for the corrective action for F441	

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C 356	Continued From page 2 facility. Soiled linen and clothing shall be collected separately in suitable bags or containers. This Rule is not met as evidenced by: Please refer to F441 as it relates to the collection of soiled linen and laundry.	C 356		
C 361	02.108,07 HOUSEKEEPING SERVICES AND EQUIPMENT 07. Housekeeping Services and Equipment. Sufficient housekeeping and maintenance personnel and equipment shall be provided to maintain the interior and exterior of the facility in a safe, clean, orderly and attractive manner. This Rule is not met as evidenced by: Please refer to F253 as it relates to maintaining a safe and sanitary environment.	C 361	C361 Refer to the 2567 for the corrective action for F253	
C 671	02.150,03,b	C 671	Refer to the 2567 for the corrective action for F441	
C 674	b. Proper handling of dressings, linens and food, etc., by staff. This Rule is not met as evidenced by: Please refer to F441 as it relates to proper handling of linens, such as pillows used by residents. 02.151,01 ACTIVITIES PROGRAM 151. ACTIVITIES PROGRAM. 01. Organized Program. There shall be an organized and supervised activity program appropriate to the needs and interests of each patient/resident. The program shall be	C 674	C674 Refer to the 2567 for the corrective action for F248	

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C 674	Continued From page 3 designed to include a variety of processes and services which are designed to stimulate patients/residents to greater self-sufficiency, resumption of normal activities and maintenance of an optimal level of psychosocial functioning. It shall include recreation, therapeutic, leisure and religious activities. This Rule is not met as evidenced by: Refer to F248 as it relates to resident activities.	C 674		
C 696	02.152 SOCIAL SERVICES 152. SOCIAL SERVICES. The facility shall provide for the identification of the social and emotional needs of the patients/residents either directly or through arrangements with an outside resource and shall provide means to meet the needs identified. The program shall be accomplished by: This Rule is not met as evidenced by: Please refer to F320 as it relates to the provision for the social and emotional needs of residents.	C 696	C696 Refer to the 2567 for the corrective action for F320	
C 733	02.154,02,b. b. Each skilled nursing patient shall be seen by the attending physician at least once every thirty (30) days for the first ninety (90) days following admission. Thereafter, an alternative schedule may be adopted for patient/ resident visits based on physician's determination of need, and so justified in the	C 733	C733 Refer to the 2567 for the corrective action for F387	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001300	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/26/2012
NAME OF PROVIDER OR SUPPLIER IDAHO FALLS CARE & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3111 CHANNING WAY IDAHO FALLS, ID 83404		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 733	Continued From page 4 patient's/resident's medical record. At no time may visits exceed ninety (90) day intervals. All physicians' visits shall be recorded in the patient's/ resident's medical record, with a physician's progress note. This Rule is not met as evidenced by: Please refer to F387 as it relates to physician visits.	C 733		
C 782	02.200,03,a,iv iv. Reviewed and revised as needed to reflect the current needs of patients/residents and current goals to be accomplished; This Rule is not met as evidenced by: Refer to F280 as it related to care plan revision.	C 782	C782 Refer to the 2567 for the corrective action for F280	
C 784	02.200,03,b	C 784	C784	
C 788	b. Patient/resident needs shall be recognized by nursing staff and nursing services shall be provided to assure that each patient/resident receives care necessary to meet his total needs. Care shall include, but is not limited to: This Rule is not met as evidenced by: Refer to F246 as it relates to accommodation of resident needs and F309 as it relates to not following the plan of care for each resident. iv. Delivery of medications, diet and treatments as ordered by the attending physician, dentist or nurse practitioner;	C 788	Refer to the 2567 for the corrective action for F246 and F309 C788 Refer to the 2567 for the corrective action for F328	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001300	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/26/2012
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NAME OF PROVIDER OR SUPPLIER IDAHO FALLS CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3111 CHANNING WAY IDAHO FALLS, ID 83404
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C 788	Continued From page 5 This Rule is not met as evidenced by: Refer to F328 as it related to oxygen administration.	C 788		
C 789	02.200,03,b,v v. Prevention of decubitus ulcers or deformities or treatment thereof, if needed, including, but not limited to, changing position every two (2) hours when confined to bed or wheelchair and opportunity for exercise to promote circulation; This Rule is not met as evidenced by: Refer to F314 as it relates to care and treatment of pressure ulcers.	C 789	C789 Refer to the 2567 for the corrective action for F314	
C 790	02.200,03,b,vi vi. Protection from accident or injury; This Rule is not met as evidenced by: Refer to F323 as it related to falls.	C 790	C790 Refer to the 2567 for the corrective action for F323	
C 797	02.200,03,c c. Nursing staff shall document on the patient/resident medical record, any assessments of the patient/resident, any interventions taken, effect of interventions, significant changes and observations and the administration of medications, treatments and any other services provided. Entries shall be made at the time the action occurs and shall be signed by the person making the entry and shall provide the time and date of the occurrence. At a minimum, a	C 797	C797 Refer to the 2567 for the corrective action for F329	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001300	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/26/2012
NAME OF PROVIDER OR SUPPLIER IDAHO FALLS CARE & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3111 CHANNING WAY IDAHO FALLS, ID 83404		
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C 797	Continued From page 6 monthly summary of the patient's/resident's condition and reactions to care shall be written by a licensed nursing staff person. This Rule is not met as evidenced by: Refer to F329 as it related to monitoring medications.	C 797		
C 881	02.203,02 INDIVIDUAL MEDICAL RECORD 02. Individual Medical Record. An individual medical record shall be maintained for each admission with all entries kept current, dated and signed. All records shall be either typewritten or recorded legibly in ink, and shall contain the following: This Rule is not met as evidenced by: Refer to F514 as it related to documentation.	C 881	C881 Refer to the 2567 for the corrective action for F514	



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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March 13, 2012

Kelly Spiers, Administrator
Idaho Falls Care & Rehabilitation Center
3111 Channing Way
Idaho Falls, ID 83404

Provider #: 135107

Dear Mr. Spiers:

On **January 26, 2012**, a Complaint Investigation survey was conducted at Idaho Falls Care & Rehabilitation Center. Lea Stoltz, Q.M.R.P., Arnold Rosling, R.N., Q.M.R.P. and Madeleine Parmley, R.N. conducted the complaint investigation. The complaint investigation was conducted in conjunction with the facility's federal Recertification and State Licensure survey.

The records of fifteen (15) residents were reviewed including the record of the identified resident. Interviews were conducted with residents, residents' families and facility staff and consultants. An environmental tour of the facility was conducted and infection control practices were observed throughout all days of the survey.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00005332

ALLEGATION #1:

The complainant stated the identified resident was admitted to the facility in October 2011. As of December 12, 2011, no care plan meeting had been held.

FINDINGS:

Based on records reviewed, staff, resident and family interviews, it was determined the care

Kelly Spiers, Administrator
March 13, 2012
Page 2 of 3

planning meetings did not always reflect family participation. The facility was cited at F280 related to Resident Assessment/Care Plan Development.

CONCLUSIONS:

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

ALLEGATION #2:

The complainant reported the identified resident had a leg wound on admission. It was a chronic wound. The wound was cultured two weeks ago and found MRSA. The MRSA was not being managed appropriately. Drainage was not contained and found on the resident's clothes and bedding. The complainant finds the resident clothes soiled with MRSA drainage on the floor of the closet. Also, found soiled linen on the floor. The identified resident sheets are dirty. The resident's urinal is on the bedside table with urine in it. The resident's bedside commode is not clean.

FINDINGS:

Based on observations, staff interviews and records reviewed, it was determined that the facility failed to ensure cleanliness of the resident's environment and ensure infection control measures were implemented. The facility was cited at F253 related to Housekeeping and Maintenance Services and at F441 related to Infection Control.

CONCLUSIONS:

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

ALLEGATION #3:

The identified resident has had a broken tooth since admission. The facility has not provided an explanation. The resident denies knowledge of how it happened.

FINDINGS:

A review of nursing notes for the resident, documented that the resident did have a chipped tooth and that an investigation was performed to determine the cause. There was nothing in the investigation to indicate the facility was at fault and the facility worked with the family to get the resident to a dentist to have it repaired.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

Kelly Spiers, Administrator
March 13, 2012
Page 3 of 3

ALLEGATION #4:

The complainant stated that facility staff did not brush the identified resident's teeth or shave him without prompts from visitors.

FINDINGS:

Based on observations, staff interviews and records reviewed, it was determined that the facility failed to ensure residents were appropriately groomed. The facility was cited at F241 related to Dignity and Respect of Individuality.

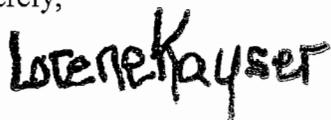
CONCLUSIONS:

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

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

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

A handwritten signature in black ink that reads "LORENE KAYSER". The letters are somewhat stylized and slanted.

LORENE KAYSER, L.S.W., Q.M.R.P., Supervisor
Long Term Care

LKK/dmj