



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 7458**

February 17, 2011

Mark F. Gunnell, Administrator  
Idaho Falls Care & Rehabilitation Center  
3111 Channing Way  
Idaho Falls, ID 83404

Provider #: 135107

Dear Mr. Gunnell:

On **February 4, 2011**, a Recertification 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. **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.** NOTE: The alleged compliance date must be after the "Date Survey Completed" (located in field X3.) After each deficiency has been answered and dated, the administrator should sign both Statement of Deficiencies and Plan of Correction, 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 **March 2, 2011**. Failure

Mark F. Gunnell, Administrator  
February 17, 2011  
Page 2 of 4

to submit an acceptable PoC by **March 2, 2011**, may result in the imposition of additional civil monetary penalties by **March 22, 2011**.

Your PoC must contain the following:

- 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 into place or what systemic changes 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; and,
- Provide dates when corrective action will be completed.

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

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

**Denial of payment for new admissions effective as soon as notice requirements can be met. [42 CFR §488.417(a)]**

A "per instance" civil money penalty of **\$3,000.00**, effective **February 4, 2011**.  
*(THIS REMEDY IS GENERALLY RESERVED FOR SITUATIONS OF SERIOUS NONCOMPLIANCE AS DESCRIBED AT §7510) (§488.430)*

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **August 4, 2011**, 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.**

Further, the Department is immediately imposing the following remedy as authorized by CMS:

**Directed In-Service Training:** Department-approved health care professional(s) from outside the Idaho Falls Care and Rehabilitation staff is to conduct this directed in-service training.

The directed in-service training must provide training on **fall prevention, injury prevention, and supervision to prevent falls**. All nursing staff employed by the facility must attend this directed in-service training.

- The Department must approve the presenter(s) of the directed in-service training prior to conducting the training.
- Completion of all required training sessions must be prior to the date the facility alleges substantial compliance.
- Please send written notification to the Bureau of Facility Standards when you have completed the in-service, including the date(s) given, who conducted it, an outline of the content and which staff members attended.

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, Post Office Box 83720, Boise, Idaho, 83720-0036; phone number: (208) 334-6626; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. 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 - Long Term Care** section and click on **State** and select the following:

- [2001-10 Long Term Care Informal Dispute Resolution Process](#)
- [2001-10 IDR Request Form](#)

Mark F. Gunnell, Administrator  
February 17, 2011  
Page 4 of 4

This request must be received by **March 2, 2011**. If your request for informal dispute resolution is received after **March 2, 2011**, 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 this office at (208) 334-6626.

Sincerely,

A handwritten signature in cursive script that reads "Loretta Todd".

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

LT/dmj  
Enclosures

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

PRINTED: 02/16/2011  
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  02/04/2011
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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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(X4) IO PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the annual recertification survey of your facility.</p> <p>The surveyors conducting the survey were:</p> <p>Lea Stoltz, QMRP, (Team Coordinator) Arnold Rosling, BSN, RN, QMRP Amy Beam, BSN, RN</p> <p>Survey Definitions: MDS = Minimum Data Set assessment DON = Director of Nursing CNA = Certified Nurse Aide LN = Licensed Nurse PT = Physical Therapist OT = Occupational Therapist RN = Registered Nurse I&amp;A = Incident and Accident Report</p>	F 000	<p>"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, <b>Idaho Falls Care &amp; Rehabilitation Center</b> 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>	
F 250 SS=D	<p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to provide medically related social service interventions to successfully address residents' needs. This was true for 2 of 13 sampled residents (#s 2 and 8), whose medical records did not contain documentation of social service assessments or interventions for 6 months each. Findings included:</p>	F 250	<p><b>F 250</b> <b>Corrective actions for residents affected:</b> Residents #2 and #8 have been assessed by Social Service on or prior to 2/23/11. The assessments have been documented in the medical record.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <i>Mark Gunnell</i>	TITLE  <i>Administrator</i>	(X6) DATE  <i>3-1-11</i>
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 250	<p>Continued From page 1</p> <p>1. Resident #8 was admitted to the facility on 2/16/05, and readmitted on 8/29/09, with diagnoses which included hemiplegia, muscular wasting and disuse atrophy, muscle weakness, and depressive disorder.</p> <p>The resident's most recent quarterly MDS assessment, dated 1/21/11, coded cognitively intact.</p> <p>The resident's February 2011 Care Plan documented the following interventions to be completed by Social Services staff: * Code status: Code status will be reviewed quarterly with [resident]/responsible party.... Will be educated on the right to change her mind at any time. * Depression: Observe for increase in symptoms: decreased appetite, weight loss, response to pleasure, increased insomnia, fatigue, feelings of worthlessness, decreased concentration, thoughts of death; note and record behaviors; recommend behavior interventions to staff; offer praise, support and positive comments; validate feelings. * Discharge: Encourage and assist to social settings and activities; help make room home-like and comfortable; Continue to review and monitor for progress that may make discharge to lower level of care possible; encourage family to bring in meaningful items from home to provide a feeling of comfort and homelike environment; encourage to use faith as a source of strength; encourage to express feelings about placement and provide reassurance.</p> <p>The resident's Interdisciplinary Progress Notes (IPNs) from Social Services documented entries</p>	F 250	<p><b>Identifying other residents having the potential to be affected, and what corrective action will be taken:</b> Resident records were reviewed by Social Services on 2/22/11 to verify a social services assessment has been completed and documented timely. Any found not complete were completed by Social Services.</p> <p><b>Measures and systemic changes to prevent recurrence:</b> Social Services was re-educated on assessment and documentation requirements by the Administrator on 2/22/11. Social Service assessments will be completed at a minimum on admission, readmission, annually and with significant change assessments with documentation in the medical record.</p> <p><b>Monitoring Corrective Action for sustained corrections:</b> Social Service or designee will audit three resident records weekly for three months for completion and documentation of Social Service assessments. Areas of concern will be addressed. POC &amp; audits will be</p>	

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F 250	<p>Continued From page 2</p> <p>on 6/11/10 and 12/9/10, with no entries between the identified dates.</p> <p>The DON was advised of the findings on 2/3/11 at 10:40 AM. She stated that any Social Services documentation would be with the other IPNs from Social Services, and that the facility had several Social Services staff changes in the past year. No further information was provided.</p> <p>2. Resident #2 was admitted to the facility on 3/8/04, and readmitted on 12/1/08, with diagnoses which included depressive disorder, bipolar I disorder, and congestive heart failure.</p> <p>The resident's most recent quarterly MDS assessment, dated 1/19/11, coded:  <ul style="list-style-type: none"> <li>* Moderate cognitive impairment</li> <li>* Feeling down, depressed, or hopeless</li> <li>* Feeling tired or having little energy</li> <li>* Antipsychotic and antidepressant use</li> </ul> </p> <p>The resident's November 2010 Care Plan documented the following interventions to be completed by Social Services staff:  <ul style="list-style-type: none"> <li>* Social service: Identify any possible stressors that may need to be eliminated; promote ability to self edit her own negative comments; praise accomplishments and follow through; observe for any signs or symptoms of increased depression; try to assist her on focusing on positive aspects of her life and routine; refer to social worker as appropriate; reassess psychotropic medications.</li> </ul> </p> <p>The resident's IPNs from Social Services documented entries on 4/19/10 and 10/19/10, with no entries between the identified dates.</p> <p>The DON was advised of the findings on 2/3/11 at</p>	F 250	<p>reviewed by the facility <b>Performance Improvement Committee monthly for three months for compliance &amp; trends and make recommendations as needed for 3 months or until resolved.</b></p> <p><b>Completion Date: 3/2/2011</b></p>		

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F 250	Continued From page 3 10:40 AM. She stated that any Social Services documentation would be with the other IPNs from Social Services, and that the facility had several Social Services staff changes in the past year. No further information was provided.	F 250		
F 252 SS=E	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT  The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.  This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to provide services to maintain a sanitary and comfortable environment. This affected 6 of 14 residents, (#s 2, 11, 17, 18, 19 & 20), whose wheelchairs were soiled or in poor repair. Findings include:  During observation in the facility's main dining room on 2/1/11 at 12:45 p.m., the following wheelchair issues were observed:  * Resident #2 utilized an electric wheelchair which had a red plastic platform covering the wheels. The platform of the chair was covered with white powder and other debris.  * Left armrest of Resident #11's wheelchair was cracked, exposing the fabric underneath.  * Resident #17's right wheelchair arm upholstery was cracked.	F 252	<b>F 252</b> <b>Corrective actions for residents affected:</b> Resident #2 - electric wheelchair was washed by nursing staff when identified during the survey and is on a routine cleaning schedule. Wheelchair armrests for resident's #11, #17, #18, #19 and #20 were replaced by the Maintenance Director on or prior to 2/10/11.  <b>Identifying other residents having the potential to be affected, and what corrective action will be taken:</b> The Maintenance Director inspected resident wheelchairs on or before 2/10/11 for any needed repairs and cleanliness. Any necessary repairs or cleaning will be performed prior to 3/1/11.  <b>Measures and systemic changes to prevent recurrence:</b> Nursing staff were re-educated by the Regional Director of Clinical Operations on or before	

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F 252	Continued From page 4 * Both left and right armrest on Resident #18's wheelchair were cracked and torn.  * Resident #19's right wheelchair arm was torn, exposing the stuffing.  * Both left and right wheelchair arms on Resident #20's wheelchair were cracked.  The Administrator was informed of the wheelchair repair/cleanliness issues on 2/2/11 at 2:30 p.m. On 2/3/11 at 8:00 a.m. the Administrator informed surveyors that repairs were already underway for the identified residents.	F 252	<b>2/26/11 on wheelchair cleaning and schedules. The Maintenance Director was re-educated on replacing worn wheelchair armrests by the Regional Director of Clinical Operations 2/9/11. Inspection of wheelchairs has been added to the monthly preventative maintenance checklist to be completed by the Maintenance Director.</b>	
F 278 SS=D	<b>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED</b>  The assessment must accurately reflect the resident's status.  A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.  A registered nurse must sign and certify that the assessment is completed.  Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.  Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money	F 278	<b>Monitoring Corrective Action for sustained corrections:</b> The Administrator or designee will complete audits of three wheelchairs weekly for three months. POC & audits will be reviewed by the facility Performance Improvement Committee monthly for compliance & trends and make recommendations as needed for 3 months or until resolved.  <b>Completion Date: 3/2/11</b>  <b>F278</b> <b>Corrective actions for residents affected:</b> Resident #3's MDS has been corrected regarding pressure	

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F 278	<p>Continued From page 5</p> <p>penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to accurately document pressure ulcers (PUs) on MDS assessments. This was true for 1 of 2 residents (#3) sampled for PUs. Findings included:</p> <p>Resident #3 was admitted to the facility on 10/7/10 with diagnoses which included Stage III PU to buttocks, coronary artery disease, peripheral vascular disease, edema, osteomyelitis, and diabetes mellitus.</p> <p>The resident's admission MDS assessment, dated 10/14/10, coded: * No current unhealed PUs, Stages I-IV (Sections M0300A-E). * 1 unstageable PU covered with eschar, present at admission (Sections M0300F1, M0300F2, and M0700).</p> <p>The resident's most recently quarterly MDS assessment, dated 1/14/11, coded: * One Stage III PU covered with slough, not present at admission; no current unhealed Stage I, II, III, or unstageable PUs (Section M0300). * No PUs which were not present or were at a lesser stage on prior assessment (Section M0800). * 1 healed Stage IV PU present on the prior assessment (Section M0900).</p>	F 278	<p>ulcer coding and re-transmitted on 2/24/11 by the MDS Coordinator &amp; the Clinical Reimbursement Manager.</p> <p><b>Identifying other residents having the potential to be affected, and what corrective action will be taken:</b> MDS's were reviewed by the Clinical Reimbursement Manager on 3/1/11 to ensure pressure ulcer coding is accurate for residents with pressure ulcers.</p> <p><b>Measures and systemic changes to prevent recurrence:</b> Staff involved in completing/coding the MDS have been re-educated by the Clinical Reimbursement Manager on 2/23/11 regarding the process for coding the MDS. Education was provided regarding how to accurately code sections. Attendees were also provided education regarding how to access the RAI/MDS Manual for future reference and additional clarification.</p> <p><b>Monitoring Corrective Action for sustained corrections:</b> Three MDS assessments will be audited weekly by the Director of Nursing or designee weekly for</p>	

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F 278	Continued From page 6 NOTE: The resident developed a PU on her left dorsal toe, which was documented to be a PU as of the date of this assessment. The other PU was present at admission.  The resident's Wound clinic records documented: * PU on the left sacrum, present at admission, documented as Stage III on 10/25/10, still present on 1/31/11. "Problems include pressure ulcer stage 4 (sic), left ischium" was documented 10/25/10-1/31/11. NOTE: The facility provided a note from the wound clinic on 2/3/11, which stated: "There is only ONE wound on the [patient's] buttocks... left sacral. References to the ischium is (sic) an error." The note did not clarify whether it was Stage III or Stage IV. * A wound on the left dorsal 2nd toe, which was documented as a PU on 1/10/11 and 1/17/11, then as a diabetic ulcer with bone exposed on 1/24/11 and 1/31/11.  On 1/31/11 at 6:55 PM, the facility's MDS nurse stated that Resident #3 had a Stage III PU on her coccyx when she was admitted to the facility, which was still present. He did not state that the resident had developed new PUs.  The 1/14/11 MDS assessment was inaccurate. Specifically, on 1/14/11, the resident had the left ischium PU which was present at admission, and a left dorsal toe PU which developed at the facility.  The DON was advised of the findings on 2/3/11 at 1:45 PM. No further information was provided.	F 278	three months to ensure accurate coding on the MDS to reflect the resident's current condition. The POC & audits will be reviewed by the facility Performance Improvement Committee monthly for compliance & trends and make recommendations as needed for 3 months or until resolved.  <b>Completion Date: 3/2/2011</b>		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS	F 279			

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F 279	<p>Continued From page 7</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to develop a care plan for the use of a knee brace for 1 of 13 sampled residents, (#1) whose care plans were reviewed. Findings include:</p> <p>Resident #1 was admitted to the facility on 9/23/10 with diagnoses of traumatic fracture of lower leg, personal history of fall, and dementia.</p> <p>Resident #1's 5 day Medicare MDS assessment, dated 9/29/10, documented the resident experienced both short- and long-term memory problems, required limited 1 person physical assistance for toileting and bed mobility,</p>	F 279	<p><b>F 279</b> <b>Corrective actions for residents affected:</b> Resident #1's care plan has been reviewed and updated by the Director of Nursing on 2/24/11 to reflect the resident's current condition to include that the knee brace was discontinued on 11/24/10.</p> <p><b>Identifying other residents having the potential to be affected, and what corrective action will be taken:</b> Resident care plans were reviewed by the Director of Nursing or designee on 2/26/11 to ensure the care plan is reflective of the resident's current condition and reflection of devices and interventions being used.</p> <p><b>Measures and systemic changes to prevent recurrence:</b> Staff involved in the care planning process were re-educated by the Director of Nursing on 2/28/11 regarding care plans reflecting the residents current condition to include use of devices used by residents.</p>	
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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  02/04/2011	
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 279	<p>Continued From page 8</p> <p>extensive 1 person physical assistance for walking and transfer. The resident was assessed as having pain daily, sometimes horrible/excruciating. The assessment stated the resident had fallen in the past 30 days and had a fracture (other than hip) in the past 180 days.</p> <p>The resident's Interdisciplinary Progress Notes from nursing documented the following information:</p> <ul style="list-style-type: none"> <li>* 9/23/10 Resident #1 was admitted to the facility on that date. "Brace on right knee" was documented as present on admit.</li> <li>* 9/26/10 at 12:50 p.m. - "Leg brace in place" No indication which leg it was on.</li> <li>* 10/5/10 (no time listed on entry) "no skin tears or bruising noted except for old, brownish bruise on [left] leg where brace rubs on leg."</li> <li>* 10/13/10 (no time listed on entry) "[unknown abbreviation] came in and looked at brace on leg so they could get the right materials to fix it so it doesn't rub."</li> <li>* 11/5/10 (no time listed on entry) "c/o [complained of] pain in [left] leg [with] brace. Brace adjusted [and] also referred to PT."</li> <li>* 11/24/10 (no time listed on entry) "DC [discontinue] leg brace."</li> </ul> <p>Occupational therapy notes documented on 11/19/10 that the resident complained of pain in the leg the brace was on, which resolved when the brace was removed. On 11/21/10, an OT note stated the resident's left knee brace was found on upside down, and reapplied correctly.</p> <p>The DON and RN clinical consultant were interviewed on 2/3/11 at 10:10 a.m. The DON confirmed the resident had been admitted with</p>	F 279	<p><b>Monitoring Corrective Action for sustained corrections:</b></p> <p>DNS or designee will complete audits of three care plans weekly for three months to ensure resident devices are accurately reflected in the care plan. POC &amp; audit will be reviewed by the facility Performance Improvement committee monthly for compliance &amp; trends and make recommendations as needed for 3 months or until resolved.</p> <p><b>Completion Date: 3/2/2011</b></p>	

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

PRINTED: 02/16/2011  
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  02/04/2011
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F 279	Continued From page 9 and used a knee brace until it was discontinued. When informed that the use of the brace was not included in the initial care plan, dated 9/23/10, or the subsequent care plan, dated 10/5/10, no comment was provided. When asked for skin integrity/treatment sheets and/or monitoring documenting treatment and prevention measures taken for the bruising and rubbing written in the nursing notes, the DON stated she would look for the information. No further information was provided.	F 279		
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 changes in care and treatment.  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.  This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, and	F 280	<p><b>F280</b> <b>Corrective actions for residents affected:</b></p> <p>Resident #9's care plan has been reviewed and updated by the DNS on 2/27/11 to accurately reflect the resident's condition.</p> <p>Resident #3's care plan was reviewed and updated by the Director of Nursing on 2/27/11 to accurately reflect the resident's plan of care.</p> <p>Resident #8 has been reviewed by the interdisciplinary team with a care plan meeting held on 2/10/11 with care plan documentation in the record.</p>	

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

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F 280	<p>Continued From page 10</p> <p>staff interview, it was determined that the facility failed to ensure that the resident care plans were updated and accurately reflected the status of the resident. This was true for 3 of 13 (#s 3, 8 and 9) sampled residents. Findings include:</p> <p>1. Resident #9 was admitted to the facility 1/13/11 with diagnoses of cellulitis and abscess of hand, diabetes without complications type II, and lower limb amputation.</p> <p>The residents most recent MDS admission assessment, dated 1/18/11, documented the resident:</p> <ul style="list-style-type: none"> <li>* had severe memory impairment,</li> <li>* required extensive assistance of one staff for transfers, dressing, personal hygiene and bathing,</li> <li>* was incontinent of bowel and bladder, and</li> <li>* had impairment of the lower extremities.</li> </ul> <p>On 2/2/11 at 10:00 a.m., the resident was interviewed. The resident, during the interview, described the incidents surrounding the loss of both of his lower extremities, which was prior to admission to the facility.</p> <p>The resident's care plan, dated 1/13/11, was reviewed. One of the interventions for the problem of "Cellulitis Care Plan" documented the staff to "inspect and monitor feet for redness, edema..." The interventions for another problem "Diabetic Care Plan" documented the staff were to do "daily foot care and observe for s/s [sign and symptom] infection."</p> <p>On 2/3/11 at 10:30 a.m., the DON was interviewed about the resident's care plan and the information about caring for feet when the</p>	F 280	<p><b>Identifying other residents having the potential to be affected, and what corrective action will be taken:</b></p> <p>A care plan review of residents in the center was conducted by DNS and/or designee on 2/26/11 to ensure the care plan reflects the resident conditions and interventions.</p> <p><b>Measures and systemic changes to prevent recurrence:</b></p> <p>Facility staff responsible for providing input/developing MDS's and care plans were re-educated by the Clinical Reimbursement Manager and/or designee on or before 3/1/11 related to care plan components and the need to ensure care plans reflect accurate and complete problems, goals and interventions. The 24-hour report is reviewed by the IDT during Administrative morning meeting and the care plan updated as appropriate. In conjunction with the MDS schedule, the care plan is reviewed. Any changes in the resident status and interventions are reflected on the care plan.</p>	
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CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/16/2011  
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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 280	<p>Continued From page 11</p> <p>resident had lost them. No further information was obtained.</p> <p>The administrator and DON were informed on 2/3/11 at 3:30 p.m. No further information was provided.</p> <p>2. Resident #3 was admitted to the facility on 10/7/10 with diagnoses which included Stage III pressure ulcer to buttocks, coronary artery disease, peripheral vascular disease, edema, osteomyelitis, and diabetes mellitus.</p> <p>The resident's admission MDS assessment, dated 10/14/10, coded: * 1 unstageable pressure ulcer covered with eschar, present at admission * 4 venous and/or arterial ulcers present * Diabetic foot ulcer</p> <p>The resident's most recently quarterly MDS assessment, dated 1/14/11, coded: * 1 Stage III pressure ulcer covered with slough * 1 healed Stage IV pressure ulcer present on the prior assessment * 3 venous and/or arterial ulcers present * Diabetic foot ulcer</p> <p>The resident's Wound clinic records documented the following Physician Orders and Plans, under "Off-Loading": * 10/7/10, 10/18/10 - Wheelchair Cushion - high profile Roho cushion needs to be order for patient and used in all seated situations. Custom felt orthotic - to the left lateral foot. Leave orthotic felt in place at this time. * 10/25/10 - Off-loading device - felt orthotic to left medial foot and podus boot. Keep weight off affected area/limb at all times. Limit sitting time.</p>	F 280	<p><b>Monitoring Corrective Action for sustained corrections:</b> DNS or designee will complete three audits of care plans weekly for three months to ensure compliance. Areas of concern will be addressed immediately. POC &amp; audits will be reviewed by the facility Performance Improvement committee monthly for compliance &amp; trends and make recommendations as needed for 3 months or until resolved.</p> <p><b>Completion Date: 3/2/2011</b></p>	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 280	<p>Continued From page 12</p> <p>Must shift sitting weight every 15 minutes or get out of chair onto bed.</p> <p>* 11/1/10 - Keep weight off affected area/limb at all times. Off-loading device - cast shoe. Seat lifts or shift position in chair every 15 minutes. Turn every 2 hours. Avoid position directing pressure to wound site. Limit side lying to 30 degree tilt. Limit head of bed elevation to 30 degrees in bed.</p> <p>* 11/17/10, 11/29/10 - Keep weight off affected area/limb at all times. Use podus boots on both lower extremities to prevent heel pressure. Examine feet daily at skilled nursing facility to prevent pressure ulcers.</p> <p>* 12/13/10 - Continue felt cutout to medial left foot.</p> <p>* 1/10/11 - Felt orthotic left second and fifth toe, also apply crow walking boot when patient is up throughout the day, and podus boot only at night.</p> <p>* 1/31/11 - Multipodus boot right lower extremity, cast boot left lower extremity</p> <p>The resident's 1/28/11 skin wound care plan documented the following interventions:                      * "Pressure relieving cushion in wheel chair to promote skin integrity and offload pressure", initiated 10/7/10 and revised on 10/22/10.                      * "Weekly skin assessments,"                      "Treatments/dressing per MD," and "Float heels as ordered," each initiated 10/7/10.                      * "Podus boot to right foot at all times," initiated 1/14/11.</p> <p>NOTE: The care plan did not contain interventions ordered by the wound clinic, including that the cushion was to be used in all seated situations; the custom felt orthotic; weight limits; sitting times; shifting position changes; bed positions; daily skin checks; walking boot; or cast boot.</p>	F 280			

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

PRINTED: 02/16/2011  
FORM APPROVED  
OMB NO. 0938-0391

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F 280	<p>Continued From page 13</p> <p>The resident's Wound clinic records documented the following pressure ulcers developed at the facility:</p> <ul style="list-style-type: none"> <li>* Pressure ulcer on an (unspecified) heel, developed as Stage III on 11/17/10 and resolved on 1/3/11</li> <li>* Pressure ulcer on the right heel lateral plantar, developed on 1/3/11 and resolved on 1/10/11</li> <li>* A wound on the left dorsal 2nd toe, which was documented as a pressure ulcer on 1/10/11 and 1/17/11, then as a diabetic ulcer with bone exposed on 1/24/11 and 1/31/11</li> </ul> <p>The DON was advised of the findings on 2/3/11 at 10:30 AM. She acknowledged that the interventions recommended by the wound clinic were not included on the resident's care plan. No further information was provided.</p> <p>3. Resident #8 was admitted to the facility on 2/16/05, and readmitted on 8/29/09, with diagnoses which included hemiplegia, muscular wasting and disuse atrophy, muscle weakness, and depressive disorder.</p> <p>The resident's most recent quarterly MDS assessment, dated 1/21/11, coded cognitively intact.</p> <p>The resident's February 2011 Care Plan documented the following focus areas: activity assistance; incontinence; assistance with personal hygiene, bathing, and dressing; cardiac deficits; code status; diagnosis of depression; risks for diabetes complications; discharge planning; risk for falls; risk for dehydration; hypothyroidism; impaired mobility, altered nutritional status; actual and potential pain; shortness of breath; and risk for skin breakdown.</p>	F 280		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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:  <b>135107</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/04/2011</b>
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F 280	Continued From page 14	F 280			
F 281 SS=D	<p>The resident's Interdisciplinary Progress Notes by the Interdisciplinary Team documented that the team did not meet to discuss the resident's care and update the care plan, between 7/29/10 and 1/27/11; for a total of 6 months.</p> <p>The DON was advised of the findings on 2/3/11 at 10:40 AM. No further information was provided.</p> <p><b>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</b></p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to provide nursing care which met professional standards of quality. This was true for 1 of 13 sampled residents (#10), who was administered a double dose of medication when a nurse failed to verify duplicate medication orders. Findings included:</p> <p>Resident #10 was admitted to the facility on 1/24/11, with diagnoses which included congestive heart failure, atrial arrhythmias, and essential hypertension. An MDS assessment had not been completed at the time of survey.</p> <p>During a medication pass observation on 2/1/11 at 9:05 AM, LN #3 was observed to pass medications to Resident #10. As LN #3 was preparing the medications for administration, the surveyor questioned LN as to whether there might be an error on the MAR (medication</p>	F 281	<p><b>F281</b> <b>Corrective actions for residents affected:</b> Resident # 10's physician was notified and the duplicate medication order was clarified by the Director of Nursing on 2/1/11 and resident was monitored for adverse effects from medication error. No adverse affects were noted. LN #3 was re-educated on appropriate med pass procedure by the Director of Nursing on 2/1/11.</p> <p><b>Identifying other residents having the potential to be affected, and what corrective action will be taken:</b> Physician orders were reviewed by the Director of Nursing on 2/23/11 to identify other residents to ensure there were no other duplicate orders. Residents will be given medications according to physician orders.</p>		

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F 281	<p>Continued From page 15</p> <p>administration record), because the MAR listed Omeprazole 20 mg (milligrams) 1 tab BID (twice daily) on page 1, and Omeprazole 20 mg 1 tab QD (daily) on page 3. LN #3 stated that she did not know if the MAR was correct, and acknowledged that she should check. She then proceeded to administer 2 Omeprazole 20 mg tablets (40 mg total) to Resident #10. Once the medication pass was complete, the surveyor checked Resident #10's medical record to verify medication orders.</p> <p>NOTE: Lippincott Williams and Wilkins' Nursing 2010 Drug Handbook documented under Safe Drug Administration, "Don't rely on the pharmacy computer system to detect all unsafe orders. Before you give a drug, understand the correct dosage, indications, and adverse effects.... Be aware of the drugs your patient takes regularly, and question any deviations from his regular routine."</p> <p>The resident's Physician's Orders (recapitulation) for January 2011 included: * Omeprazole 20 mg orally QD (daily) for GERD (gastroesophageal reflux disease), started 1/24/11</p> <p>The resident's Physician's Orders (recapitulation) for February 2011 included: * Omeprazole 20 mg orally, 1 tab BID for GERD, started 1/30/11</p> <p>A 1/28/11 hand written Physician's Order documented, "Increase Omeprazole to 20 mg: 1 PO BID."</p> <p>The DON was advised of the findings on 2/1/11 at 10:00 AM. At 3 PM on 2/1/11, she stated, "We meant to discontinue the Omeprazole QD."</p>	F 281	<p><b>Measures and systemic changes to prevent recurrence:</b> Licensed nurses have been re-educated by the Regional Director of Clinical Operations on or before 2/26/11 on medication administration policies and procedures. Physician orders will be reviewed by the Director of Nursing or designee in the morning clinical meeting for duplication of orders.</p> <p><b>Monitoring Corrective Action for sustained corrections:</b> DNS or designee will complete three audits weekly for three months of medication administration. POC &amp; audits will be reviewed by the facility Performance Improvement Committee monthly for compliance &amp; trends and make recommendations as needed for 3 months or until resolved.</p> <p><b>Completion Date: 3/2/2011</b></p>	

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F 281	Continued From page 16	F 281		
F 309 SS=D	<p>Resident #10 was administered 40 mg of Omeprazole, when 20 mg was ordered. LN #3 did not verify physician orders prior to administration, after she acknowledged that she should question the duplicate MAR entry.</p> <p><b>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</b></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 and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to intervene or notify the physician for residents with abnormal vital signs, or to provide bowel care to prevent constipation. This was true for 3 of 13 sampled residents (#s 2, 3, and 8). This applied specifically to: 1) Resident #2 had abnormal vital signs documented, without indication that nurses were aware of, intervened for, or notified the physician. 2) Residents #2, 3, and 8 were not provided bowel care as needed. Findings included:  The DON provided surveyors with the facility's "BM List." It was a worksheet with instructions that indicated it was to be completed daily, and "Residents who have not had a BM by the morning of the 3rd day need to be put on this list." It included columns to list the resident, number of</p>	F 309	<p><b>F309</b> <b>Corrective actions for residents affected:</b> Resident #2 has been re-assessed by Director of Nursing or designee 2/25/11 for adverse outcomes from abnormal vital signs. No adverse outcomes were noted.</p> <p>Resident's #2 have been re-assessed by the Director of Nursing on 2/25/11 regarding their bowel care protocol. Residents #3 and #8 have been re-assessed by the Director of Nursing or designee on 3/1/11.</p> <p><b>Identifying other residents having the potential to be affected, and what corrective action will be taken:</b> The Director of Nursing and Staff Development Coordinator reviewed resident records on or before 2/9/11 for bowel movements and vital signs to</p>	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	<p>Continued From page 17</p> <p>days since last BM, medication given, and results. The bottom of the page documented, "Possible interventions - make sure there is an order or you call the MD and get an order before you give these meds. If no BM by the morning of the 3rd day - MOM 30 mls (milk of magnesia 30 milliliters); if no results by 4th day - dulcolax suppository in [morning]; if no results from suppository - fleets enema at [bedtime]; if no results by morning of 5th day, call MD."</p> <p>1. Resident #2 was admitted to the facility on 3/8/04, and readmitted on 12/1/08, with diagnoses which included congestive heart failure (CHF), diabetes mellitus type II, hypothyroidism, history of atrial fibrillation, depressive disorder, bipolar I disorder, and hypertension.</p> <p>The resident's most recent quarterly MDS assessment, dated 1/19/11, coded:          * Moderate cognitive impairment          * Antipsychotic and antidepressant use          * Active diagnoses of heart failure, hypertension, and diabetes mellitus          * Always continent of bowel          * Total dependence on 2 or more staff for toilet use</p> <p>The resident's 2/1/11 Care Plan documented:          * Focus: alteration in health: multiple cardiac diagnoses, CHF, edema, hypertension, and atrial fibrillation, initiated on 10/29/08 and most recently updated on 1/27/10. The goal was to have no signs or symptoms of shortness of breath, edema, or elevated blood pressure, and no exacerbation of cardiac diagnoses. Interventions included:          - Observe for signs and symptoms of CHF, including dyspnea and tachycardia</p>	F 309	<p>identify others and orders were obtained as necessary. Residents with abnormal vital signs will be reported to the licensed nurse for follow-up.</p> <p><b>Measures and systemic changes to prevent recurrence:</b>          Nursing staff have been re-educated by the Regional Director of Clinical Operations on or before 2/26/11 on completing, documenting and reporting abnormal vital signs.</p> <p>Nursing staff have been re-educated by the Regional Director Clinical Operations on or before 2/26/11 on bowel care and documentation.</p> <p><b>Monitoring Corrective Action for sustained corrections:</b>          DNS or designee will complete three audits weekly for three months of vital signs and bowel records. Areas of concern will be addressed. POC &amp; audits will be reviewed by the facility Performance Improvement committee monthly for compliance &amp; trends and make recommendations as needed for 3 months or until resolved.</p> <p><b>Completion Date: 3/2/2011</b></p>		

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

PRINTED: 02/16/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135107</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/04/2011</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	<p>Continued From page 18</p> <ul style="list-style-type: none"> <li>- Observe for signs and symptoms of hypertension, including increased blood pressure (BP)</li> <li>- Report abnormal results to physician</li> <li>* Focus: requires assistance with toileting related to neuropathy, prior CVA (cerebrovascular accident), obesity. Interventions included: One person extensive assist needed for toileting needs for safety, adjusting clothing, peri care, etc.</li> </ul> <p>The resident's February 2010 Physician's Orders (recapitulation) did not include any PRN (as needed) bowel care medications or standing orders for bowel care, but did include:</p> <ul style="list-style-type: none"> <li>* Dulcolax 10 mg by mouth every day, for constipation</li> <li>* Lasix 80 mg by mouth every morning, for edema</li> <li>* Lasix 40 mg by mouth every afternoon for edema</li> <li>* Neurontin 600 mg by mouth twice daily for diabetes</li> <li>* Prilosec 20 mg by mouth every day for gastroesophageal reflux disease</li> <li>* Tramadol 50-100 mg by mouth every 4 hours if needed for pain</li> <li>* Zoloft 100 mg by mouth every day for depressive disorder</li> <li>* Depakote ER 1000 mg by mouth every day for bipolar disorder</li> <li>* Zyprexa 2.5 mg by mouth every evening for bipolar disorder</li> </ul> <p>NOTE: Lippincott, Williams and Wilkins' Nursing 2010 Drug Handbook lists constipation as a potential adverse reaction for the the following medications: Lasix, Neurontin, Prilosec, Tramadol, Zoloft, Depakote, and Zyprexa.</p> <p>a) The resident's Vital Signs flow sheet</p>	F 309			

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

PRINTED: 02/16/2011  
FORM APPROVED  
OMB NO. 0938-0391

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F 309	<p>Continued From page 19</p> <p>documented the following abnormal vital signs:</p> <ul style="list-style-type: none"> <li>* 9/27/10 - BP 171/48</li> <li>* 10/6/10 - BP 164/86, pulse 95</li> <li>* 11/13/10 - oxygen saturation 84%</li> <li>* 1/6/11 - pulse 48</li> <li>* 1/15/11 - 168/74</li> </ul> <p>The resident's medical record did not contain Condition Change Forms or Interdisciplinary Progress Notes to document that nurses were aware of, intervened for, or notified the physician of the abnormal vital signs.</p> <p>b) Resident #2's 1/12/11 Medical Nutrition Therapy Assessment documented that the resident experienced constipation.</p> <p>Resident #2's Resident Functional Performance Records (FPRs) for October through December 2010 documented no bowel movements during the following time frames:</p> <ul style="list-style-type: none"> <li>* October 5-8 (4 days)</li> <li>* November 14-18 (5 days)</li> <li>* December 6-9 (4 days)</li> </ul> <p>The resident's MARs for October through December 2010 documented that no PRN bowel care medications were administered.</p> <p>The DON was advised of the findings on 2/3/11 at 10:35 AM.</p> <ul style="list-style-type: none"> <li>* She stated, "The CNAs are supposed to enter the vital signs in the chart and notify the nurses." She was asked to provide documentation to indicate that the nurses were made aware of the abnormal vital signs, intervened in any way, or notified the physician.</li> <li>* She provided BM Lists which documented: <ul style="list-style-type: none"> <li>* 10/8/10 - 3 days since last BM; no medication given; results: medium BM</li> </ul> </li> </ul>	F 309			

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

PRINTED: 02/16/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135107</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/04/2011</b>
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F 309	<p>Continued From page 20</p> <ul style="list-style-type: none"> <li>* 11/18/10 - 4 days since last BM; no medication given; results: has BMs daily</li> <li>* 12/10/10 - 5 days since last BM; no medication given; results: large BM</li> </ul> <p>2. Resident #3 was admitted to the facility on 10/7/10 with diagnoses which included chronic kidney disease, edema, rheumatoid arthritis, muscular wasting and disuse atrophy, diabetes mellitus, and congestive heart failure.</p> <p>The resident's admission MDS assessment, dated 10/14/10, coded cognitively intact, frequently incontinent of bowel and bladder, and extensive assistance by 1 staff for toilet use and personal hygiene. The CAA associated with the assessment documented: "She is alert and able to make her needs known. She is on a toileting program. Dietary, therapy and nursing have assessed."</p> <p>The resident's most recent quarterly MDS assessment, dated 1/14/11, coded cognitively intact, occasionally incontinent of bowel and bladder, and extensive assistance by 1 staff for toilet use and personal hygiene.</p> <p>Resident #3's 1/28/11 bowel care plan documented the intervention, "Record BM, note size and consistency. Report any abnormalities to licensed nurse," initiated 10/7/10.</p> <p>The resident's Physician Orders (recapitulation) for February 2011 included:</p> <ul style="list-style-type: none"> <li>* Hydrocodone-acetaminophen 10/325 mg by mouth every 6 hours for pain</li> <li>* Hydrocodone-acetaminophen 10/325 mg, 1-2 tabs by mouth every 4 hours as needed for pain</li> <li>* Flexeril 10 mg by mouth every 8 hours PRN</li> </ul>	F 309			

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

PRINTED: 02/16/2011  
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  02/04/2011
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F 309	<p>Continued From page 21</p> <p>muscle spasms</p> <ul style="list-style-type: none"> <li>* Lasix 40 mg by mouth every day for edema</li> <li>* Neurontin 300 mg by mouth every day for neuropathy</li> <li>* Xanax 0.25 mg by mouth three times daily for anxiety</li> <li>* Lexapro 20 mg by mouth every day (no diagnosis)</li> <li>* Miralax 17 gm by mouth every day for constipation</li> </ul> <p>NOTE: Lippincott, Williams and Wilkins' Nursing 2010 Drug Handbook lists constipation as a potential adverse reaction for the the following medications: Hydrocodone, Flexeril, Lasix, Neurontin, Xanax, and Lexapro.</p> <p>Resident #2's Resident FPR for November and December 2010 documented no bowel movements during the following time frames:</p> <ul style="list-style-type: none"> <li>* November 5-9 (6 days)</li> <li>* November 15-20 (6 days)</li> <li>* November 26-30 (5 days)</li> <li>* December 10-15 (6 days)</li> </ul> <p>The resident's MARs for November and December 2010 documented that no PRN bowel care medications were administered.</p> <p>The DON was advised of the findings on 2/3/11 at 10:35 AM. She provided BM Lists which documented:</p> <ul style="list-style-type: none"> <li>* 11/8/10 - 3 days since last BM; Miralax given; results: large BM</li> <li>* 11/18/10 - 3 days since last BM; Miralax given; results: medium BM</li> <li>* 11/19/10 - 4 days since last BM; Milk of Magnesia (MOM) given; results: large BM</li> <li>* 11/30/10 - 3 days since last BM; Miralax given; results: large BM</li> </ul>	F 309		

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

PRINTED: 02/16/2011  
FORM APPROVED  
OMB NO. 0938-0391

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F 309	<p>Continued From page 22</p> <ul style="list-style-type: none"> <li>* 12/14/10 - 4 days since last BM; Miralax given; results: extra large BM</li> <li>* 12/15/10 - 5 days since last BM; no medication given; results: extra large BM</li> </ul> <p>NOTE: These forms contradicted the resident's FPR and MAR documentation. In addition, the documentation on the forms was contradictory from day to day.</p> <ul style="list-style-type: none"> <li>- 11/18/10 the form documented a medium BM; on 11/19/10, 4 days since the last BM</li> <li>- 12/14/10 the form documented an extra large BM; on 12/15/10, 5 days since the last BM</li> <li>- Miralax was a routine daily medication - interventions for constipation should go above and beyond the resident's routine daily medications.</li> <li>- The medical record did not contain any evidence of physician contact or PRN bowel care medication orders.</li> <li>- MOM was documented to be administered, on the BM List, on 1/19/10. The MAR did not document that administration, the resident did not have a physician order documented, and the BM List was not part of the resident's medical record (it was provided by the DON after the surveyor reviewed the medical record).</li> </ul> <p>On 2/3/11 at 3:15 PM, the DON was asked about the conflicting documentation and lack of physician orders for medications which were documented to be administered. She had no comment.</p> <p>3. Resident #8 was admitted to the facility on 2/16/05, and readmitted on 8/29/09, with diagnoses which included hemiplegia, muscular wasting and disuse atrophy, muscle weakness, and depressive disorder.</p>	F 309			

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

PRINTED: 02/16/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135107</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/04/2011</b>
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F 309	<p>Continued From page 23</p> <p>The resident's most recent quarterly MDS assessment, dated 1/21/11, coded:</p> <ul style="list-style-type: none"> <li>* Cognitively intact</li> <li>* Extensive assistance by 1 person for toilet use, personal hygiene, and bathing</li> <li>* Frequently incontinent of bowel</li> </ul> <p>The resident's February 2011 Care Plan documented the focus of alteration in health related to diagnosis of hypothyroidism. The only intervention for bowel care or constipation in the care plan was, "observe for extreme fatigue, dry skin, hair loss, brittle nails, intolerance to cold, apathy, bradycardia, weight gain, decreased LOC (level of consciousness), cardiac complications, constipation, increased agitation, appetite changes," initiated 8/29/09.</p> <p>Physician's Orders (recapitulation) for February 2011 included:</p> <ul style="list-style-type: none"> <li>* Norco 5/325 mg by mouth every 4 hours PRN pain</li> <li>* Norco 5/325 mg by mouth three times daily for pain</li> <li>* Lasix 40 mg by mouth daily for hypertension</li> <li>* Neurontin 100 mg by mouth three times daily for restless leg syndrome</li> <li>* Baclofen 10 mg by mouth daily for muscle spasms</li> <li>* Requip 1 mg by mouth every day for restless leg syndrome</li> <li>* Simvastatin 20 mg by mouth every day for hyperlipidemia</li> <li>* Zoloft 25 mg by mouth every day for depressive disorder</li> <li>* Benefiber 1 teaspoon by mouth daily PRN constipation</li> <li>* Colace 100 mg by mouth PRN twice daily for constipation</li> </ul>	F 309			

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

PRINTED: 02/16/2011  
FORM APPROVED  
OMB NO. 0938-0391

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F 309	<p>Continued From page 24</p> <ul style="list-style-type: none"> <li>* MOM 30 ml (milliliters) by mouth PRN for constipation</li> <li>* Miralax 17 gm by mouth PRN daily for constipation</li> </ul> <p>NOTE: Lippincott, Williams and Wilkins' Nursing 2010 Drug Handbook lists constipation as a potential adverse reaction for the the following medications: Norco, Lasix, Neurontin, Baclofen, Requip, Simvastatin, and Zoloft.</p> <p>The resident's MARs for November and December 2010 documented:</p> <ul style="list-style-type: none"> <li>* October 2010: MOM on 10/4 and 10/28</li> <li>* November 2010: MOM on 11/8</li> <li>* December 2010: Colace on 12/1 and 12/6; MOM on 12/6</li> <li>* January 2011: Miralax on 1/31</li> </ul> <p>No other PRN bowel care medications were documented to be administered.</p> <p>Resident FPR for October 2010 through January 2011 documented no bowel movements during the following time frames:</p> <ul style="list-style-type: none"> <li>* October 1-4 (4 days), October 17-22 (6 days), and October 24-30 (7 days)</li> <li>* November 4-9 (6 days)</li> <li>* December 2-5 (4 days)</li> <li>* January 11-14 (4 days), January 16-19 (4 days), and January 28-31 (4 days)</li> </ul> <p>The DON was advised of the findings on 2/3/11 at 10:35 AM. She provided BM Lists which documented:</p> <ul style="list-style-type: none"> <li>* 10/5/10 - 4 days since last BM; no medication given; results: medium BM</li> <li>* 10/30/10 - 4 days since last BM; no medication given; results: large BM</li> <li>* 11/8/10 - 4 days since last BM; MOM given; results: large BM</li> </ul>	F 309		

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

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FORM APPROVED  
OMB NO. 0938-0391

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F 309	<p>Continued From page 25</p> <ul style="list-style-type: none"> <li>* 12/5/10 - 3 days since last BM; no medication given; results: large BM</li> <li>* 1/15/11 - 3 days since last BM; no medication given; results: extra large BM</li> <li>* 1/19/11 - 3 days since last BM; no medication given; results: 2 small BMs</li> <li>* 1/20/11 - 3 days since last BM; no medication given; results: large BM</li> <li>* 1/31/11 - 4 days since last BM; Miralax given; no results</li> </ul> <p>NOTE: These forms contradicted the resident's FPR and MAR documentation. In addition, the documentation on the forms was contradictory from day to day.</p> <ul style="list-style-type: none"> <li>- 11/8 the form documented a large BM; the FPR documented no BM until 11/10</li> <li>- 1/19 the form documented 3 days since the last BM, then 2 small BMs; on 1/20, 3 days since the last BM</li> </ul> <p>The facility did not provide evidence that anyone compared and contrasted the various elements of documentation to track the resident's actual bowel activity with interventions, and eliminate inconsistencies in documentation/ medication administration so the resident's highest practicable well being could be maintained. The net results were summarized below:</p> <ul style="list-style-type: none"> <li>* 10/1-4/10 - 4 days without BM</li> <li>* 10/17-22/10 - 6 days without a BM</li> <li>* 10/24-30/10 - 7 days without a BM</li> <li>* 11/4-9/10 - 5 days without a BM</li> <li>* 12/2-5/10 - 4 days without a BM</li> <li>* 1/11-14/11 - 4 days without a BM</li> <li>* 1/16-19/11 - 4 days without a BM</li> <li>* 1/28-31/11 - 4 days without a BM</li> </ul> <p>The resident had active orders for multiple PRN bowel care medications, but they were not</p>	F 309		

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

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FORM APPROVED  
OMB NO. 0938-0391

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F 309	Continued From page 26 consistently administered. The BM Worksheet instructions documented possible interventions for the 3rd, 4th, and 5th day the resident did not have a BM. The medical record did not contain any evidence of physician contact, although the resident was documented to go without a BM for up to 7 days.  On 2/3/11 at 3:15 PM, the DON was asked about the conflicting documentation and lack of physician orders for medications which were documented to be administered. She had no comment.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS  A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.  This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, it was determined the facility failed to ensure that residents received a shower/bath weekly. This was true for 3 of 13 (#s 3, 8 and 12) sampled residents. Findings include:  1. Resident #12 was admitted to the facility on 2/20/10, and readmitted on 1/7/11, with diagnoses of; aftercare following joint replacement, knee joint replacement, bipolar and depressive disorder.  The most recent quarterly MDS assessment, dated 12/7/10, documented that the resident:	F 312	<b>F312</b> <b>Corrective actions for residents affected:</b> Shower schedules were reviewed by the Staff Development Coordinator for residents #3 and #8 and showers were provided for those residents when identified. Resident #12 was discharged from the facility on 2/13/11.  <b>Identifying other residents having the potential to be affected, and what corrective action will be taken:</b> Residents residing in the facility have the potential to be affected. A review of shower schedules and documentation was completed by the Regional Director of Clinical Operations.	

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

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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  02/04/2011
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 312	<p>Continued From page 27</p> <ul style="list-style-type: none"> <li>* cognition was moderately impaired (C0500),</li> <li>* was moderately depressed (D0300),</li> <li>* had no refusal of cares (E0800),</li> <li>* required extensive assistance of one staff for transfer, dressing, eating and personal hygiene,</li> <li>* did not receive a bath in the 7 days of the assessment (G0120).</li> </ul> <p>The resident's care plan, dated 7/14/10, documented at "ADL/Bathing Care Plan" an intervention of "Bathing: 1 person to provide physical assist. - CNA - qweek [each week]" The care plan also documented at "Behavior Care Plan: [Resident #12] has been refusing cares" as evidenced by "taking showers. She has not been violent when refusing cares..." Some of the interventions were:</p> <ul style="list-style-type: none"> <li>* Determine best time of day to approach [Resident #12] for a shower and possibly preferred caregivers, applying preferences as possible,</li> <li>* Educate Resident to facility's responsibility to maintain safety and cleanliness, and</li> <li>* Discontinue attempts if resident become resistant, document attempts and Resident's response.</li> </ul> <p>The resident's September 2010 "Resident Functional Performance Record [RFPR]" documented for bathing, the resident had a bath on 9/3/10 and 9/10/10. The resident was offered and refused a bath one time on 9/7/10, 9/14/10, 9/17/10, 9/21/10, 9/24/10, and 9/28/10. The form had an area for nights, days, and evenings staff to document. All the other days and times have "NA" in the boxes.</p> <p>The resident's October 2010 "RFPR" documented for bathing, the resident had a bath on 10/5/10</p>	F 312	<p>on 2/8/11 to ensure residents receive showers accordingly.</p> <p><b>Measures and systemic changes to prevent recurrence:</b> Nursing staff have been re-educated by the Regional Director of Clinical Operations on or prior to 2/26/11 regarding ADL care and hygiene and the importance of providing showers to residents according to the schedule and documenting accurately. Education also included appropriate handling of resident refusals and reporting refusals to social services.</p> <p><b>Monitoring Corrective Action for sustained corrections:</b> DNS or designee will complete three audits weekly for three months of shower records to ensure compliance. Areas of concern will be addressed. POC &amp; audits will be reviewed by the facility Performance Improvement committee monthly for compliance &amp; trends and make recommendations as needed for 3 months or until resolved. Re-education will occur as needed.</p> <p><b>Completion Date: 3/2/2011</b></p>	

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

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F 312	<p>Continued From page 28</p> <p>and 10/26/10. The resident was offered and refused a bath one time on 10/1/10, 10/8/10, 10/12/10, 10/19/10, 10/22/10 and 10/30/10. The form had an area for nights, days, and evenings staff to document. All the other days and times have "NA" in the boxes.</p> <p>The resident's November 2010 "RFPR" documented for bathing, the resident had a bath on 11/12/10 and 11/30/10. The resident was offered and refused a bath one time on 11/2/10, 11/5/10 and 11/9/10. The form had an area for nights, days, and evenings staff to document. All the other days and times have "NA" in the boxes.</p> <p>The resident's December 2010 "RFPR" documented for bathing, the resident had a bath on 12/17/10 and 12/18/10. The resident was offered and refused a bath one time on 12/3/10, 12/7/10, 12/10/10, 12/14/10, 12/21/10 and 12/28/10. The form had an area for nights, days, and evenings staff to document. All the other days and times have "NA" in the boxes.</p> <p>The administrator and DON were informed of the lack of bathing on 2/3/11 at 3:30 p.m. No additional information was provided.</p> <p>2. Resident #3 was admitted to the facility on 10/7/10 with diagnoses which included pressure ulcers, osteomyelitis, edema, and anxiety.</p> <p>The resident's 10/14/10 admission MDS assessment coded: * Cognitively intact * Physical help required by one person for bathing activities.</p> <p>The resident's 1/14/11 quarterly MDS</p>	F 312		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 312	<p>Continued From page 29</p> <p>assessment coded: * Cognitively intact * Bathing activity did not occur during the previous 7 days</p> <p>The resident's 1/28/11 ADL care plan documented self care deficit, weakness, decreased balance, impaired coordination, pain, and decreased sensation. The goal was to be odor free, appropriately dressed, groomed, and needs to be met daily. Interventions included: * "Adjust level of care according to individual needs and report persistent changes to physician and family," initiated 10/7/10 * "Baths and showers per schedule and PRN. Skin check, shower, shampoo hair, nail cares, and lotion PRN," initiated 10/7/10 NOTE: A specific frequency or schedule for bathing was not included. Other surveyed residents in the facility had care plans which specified 1 bath per week.</p> <p>The resident's RFPRs for October 2010 through January 2011 documented the following periods without bathing activity: * October 27- November 6: no baths or refusals (11 days) * December 24-January 2: no baths, 1 refusal on 12/27/10 (10 days) * January 7-23: no baths or refusals (17 days) * January 25-31: no baths, 2 refusals on 1/27/11 and 1/31/11 (7 days) NOTE: The medical record did not contain documentation of any attempts to reapproach the resident after refusals; any explanation of the extended periods between bathing; or any care plan modifications to ensure that the resident's care planned goals were met.</p>	F 312		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 312	<p>Continued From page 30</p> <p>The DON was advised of the findings on 2/3/11 at 10:30 AM. No further information was provided.</p> <p>3. Resident #8 was admitted to the facility on 2/16/05, and readmitted on 8/29/09, with diagnoses which included hemiplegia, muscular wasting and disuse atrophy, muscle weakness, and depressive disorder.</p> <p>The resident's most recent quarterly 1/21/11 MDS assessment coded cognitively intact, extensive assistance by 1 person for personal hygiene and bathing, and frequently incontinent of bowel and bladder.</p> <p>The resident's February 2011 Care Plan documented:            * ADL/Personal hygiene: Provide continual supervision with physical assist, i.e. comb hair, brushing teeth, etc. There are some tasks that [the resident] is able to perform and others that she requires assistance with in regards to hygiene tasks.            * ADL/Bathing: To receive baths as scheduled and assist as she is able. Prefers shower. One person to provide physical assist. Ensure hair is washed and nails are clean on bathing day.            * Depression: Observe for increase in symptoms: fatigue, feelings of worthlessness, decreased concentration; note and record behaviors; recommend behavior interventions to staff; offer praise, support and positive comments; validate feelings.            NOTE: A specific frequency or schedule for bathing was not included. Other surveyed residents in the facility had care plans which specified 1 bath per week.</p> <p>The resident's RFPR for October 2010 through</p>	F 312			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 312	Continued From page 31 January 2011 documented the following periods without bathing activity documented: * October 1-6: no baths or refusals (6 days) * October 8-15: no baths or refusals (8 days) NOTE: 1 bath in 15 days	F 312		
F 314 SS=G	The DON was advised of the findings on 2/3/11 at 10:30 AM. No further information was provided. 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, record review, and staff interview, it was determined the facility failed to ensure that residents received appropriate care and treatment for pressure ulcers. This was true for 3 of 13 (#s 3, 4 and 13) sampled residents. Two residents, #3 and #4, were harmed when the facility failed to: * modify care plans to meet resident needs related to pressure ulcer care, * care plan and/or implement wound clinic recommendations, * provide and document interventions when skin problems occurred, and * provide accurate documentation for location, treatments and interventions when sores were	F 314	<b>F314</b> <b>Corrective actions for residents affected:</b> Resident #3 and #13 have been assessed to ensure their status is accurate and appropriate pressure ulcer care and treatment interventions are in place, to include orders reviewed and care plans updated on or before 2/28/11 by the Director of Nursing. Resident #4 discharged from the facility on 2/17/11.  <b>Identifying other residents having the potential to be affected, and what corrective action will be taken:</b> Residents identified as at-risk for skin breakdown or pressure ulcers have been identified and reviewed by a licensed nurse on or before 2/26/11 to ensure interventions were implemented and documented on the care plan.	

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F 314	<p>Continued From page 32 identified.</p> <p>Resident #4 developed recurrent Stage 2 pressure ulcers. Resident #3, who was admitted with wounds, developed at least one additional Stage 2 pressure ulcer and two additional Stage 3 pressure ulcers. Findings include:</p> <p>1. Resident #4 was admitted to the facility 6/26/06, and readmitted on 4/17/09, with diagnoses of Alzheimer's disease, deficiencies of limbs and contracture of hand joint.</p> <p>The resident's most recent quarterly MDS assessment, dated 12/2/10, documented that the resident:</p> <ul style="list-style-type: none"> <li>* had short and long term memory problems,</li> <li>* decision making skills were severely impaired,</li> <li>* required total assistance of one staff for transfers, dressing, eating, personal hygiene and bathing,</li> <li>* was incontinent of bowel and bladder,</li> <li>* was at risk for pressure sores but did not have one.</li> </ul> <p>The resident's medical record contained three areas of documentation. Nursing documentation was completed on the "Interdisciplinary Progress Notes" form. Nursing entries were in 3 sections of the medical record. The three areas were: 1) daily progress notes that licensed nursing completed, 2) Interdisciplinary team (IDT) meeting documentation, and 3) wound care nurse documentation. The chronological events were extracted from all three areas.</p> <p>*Ongoing documentation between 2/10/10 and 6/1/10 noted red or open excoriation to the resident's left and right buttocks, the coccyx, penis and scrotum. On 3/15/10, the facility received a new order to, "Cleanse area to right</p>	F 314	<p><b>Measures and systemic changes to prevent recurrence:</b></p> <p>The Regional Director of Clinical Operations re-educated staff on or before 2/26/11 regarding wound and skin policy and procedures.</p> <ul style="list-style-type: none"> <li>• Weekly skin checks</li> <li>• Residents at risk for skin breakdown.</li> <li>• New wounds are reviewed in the morning administrative meeting.</li> <li>• Residents with current pressure ulcers and at risk for skin breakdown are reviewed in C.A.R.E meeting by the IDT for status of wounds, treatments &amp; interventions in place.</li> <li>• Skin care &amp; pressure ulcer prevention and management.</li> </ul> <p>Ambassador rounds will be completed to monitor for preventive devices. Pressure ulcers are reviewed weekly by the Director of Nursing for status of wound, treatment, current physician orders and to ensure that weekly wound rounds are completed. Documentation will be completed on the "Pressure</p>	

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F 314	Continued From page 33 lower buttocks with wound cleanser, apply skin prep, cover with hydrocolloid..." On 3/29/10, the order was changed to: 1) Discontinue hydrocolloid to buttocks. 2) apply medseptic to coccyx/buttocks twice a day..." A 4/21/10 note documented, "Resident has treatment order for lanaseptic to coccyx bid [two times a day]..." By 6/23/10, all excoriation was noted to be resolved. * 10/10/10 - 3:30 a.m. - "Resident noted to have 1 cm [centimeter] open area to coccyx and 1 cm by 1 cm open area on right buttock next to coccyx. Area cleaned with normal saline..." * 10/11/10 - "Noted open areas times 2 to coccyx. Open/non-blanching clinically appearing stage 2 pressure areas. Areas cleansed with normal saline. Mediseptic barrier cream applied per MD order...Resident placed on a LAL [low air loss] mattress..." * 10/13/10 - "IDT Note:...Noted skin breakdown to coccyx stage II is on LAL mattress..." * 10/14/10 - "IDT Note - On 10/11/10 at 6:00 p.m. noted 2 clinically appearing stage II pressure areas x 2 to coccyx...MD ordered to continue with application of lanaseptic to coccyx twice daily. Resident nutritionally compromised - has been working with speech therapy for dysphasia. Resident placed on NPO [nothing by mouth] status PEG tube was placed on 10/8/10 and tube feeding was initiated. Resident was placed on a LAL mattress immediately to offload pressure - Norton scale revealed a 3 [Norton score of 10 or less is high risk] on 10/11/10, wounds are improving..." * 10/14/10 - "Skin check, noted 1 open area today #2 appears resolved. #1 clinically appears stage II, area does appear to be blanching today. Resident continues on LAL mattress with heels bridged..." NOTE: See below for explanation of #1 and #2.	F 314	Ulcer Documentation Form," weekly. The care plan will be reviewed and updated to reflect current resident status & interventions as needed.  <b>Monitoring Corrective Action for sustained corrections:</b> DNS or designee will complete three audits weekly for three months of residents with pressure ulcers and at-risk for skin breakdown to ensure interventions and treatments currently ordered are in place and care planned. The POC and audits will be reviewed by the facility Performance Improvement committee monthly for compliance & trends and make recommendations as needed for 3 months or until resolved.  <b>Completion Date: 3/2/2011</b>	

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F 314	Continued From page 34 * 10/21/10 - "Coccyx checked. Area (#1) appears closed, 100% epithelialized, no new skin issues noted..." * 10/22/10 - "Noted area to inner buttocks open, red/blanching small amount serosanguous drainage...appears to be a stress tear..." * 10/28/10 - "Skin check,...coccyx area small open area as noted previously..." * 11/11/10 - "Skin check, area to coccyx 100% epithelialized..." * 12/22/10 - "Skin check, skin intact, noted excoriation to left buttocks, barrier cream applied..." * 12/27/10 - "Therapy recommendation: ROJO cushion in wheelchair to promote skin integrity..." * 12/27/10 - "Noted Clinically appearing stage 2 area to right ischial..." (This note had an X drawn across it with the words ERROR and a new note was done 1/3/11.) * 1/3/11 - "Late entry for 12/27/10. Abrasion area noted to Right ischial area, MD/Family notified..." * 1/6/11 - "Skin check, no new skin issues noted..." * 1/16/11 - 2:30 a.m. - "Resident resting comfortably...Open area to right buttocks, cleansed with normal saline, optiform dressing applied, treatment nurse notified..." * 1/17/11 - "Skin has wound to right lower buttocks and some excoriation to coccyx and scrotum. Dressing applied to wound and cream applied to excoriation." * 1/18/11, 1/19/11, 1/20/11, 1/21/11, 1/24/11, 1/26/11, and 1/27/11 documented the wound on the right buttock was cleaned and dressed. * 1/31/11 - "Skin wound to right buttock cleaned and dressed. Dark brown in color. MD notified immediately. Wound culture orders obtained and consult with wound clinic..." * 2/1/11 - "Skin wound to right buttock/ischial	F 314		

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F 314	<p>Continued From page 35</p> <p>cleaned and dressed. Resident on LAL mattress and when up to meals has a pressure relieving cushion on wheelchair. Wound has an absorptive dressing applied..."</p> <p>There were two "Pressure Ulcer Documentation Form" for sores that were noted on 10/11/10 - The sites were labeled as "Coccyx #1" and "Coccyx #2." The exact location of the sores was not described in any documentation, only that there were two sores on the coccyx. The documentation for Coccyx #1 was:  * 10/11/10 - Staged the sore as a "2" with a length of 2.2 cm and width of 1.9 cm with no tunneling, exudate or pain.  * 10/20/10 - Staged the sore as a "1" with a length of 2.0 cm and width of 2.0 cm with no tunneling, exudate or pain.  * 10/21/10 - Staged as "0" and then "resolved" written across the line.</p> <p>The documentation for the "Coccyx #2" sore was:  * 10/11/10 - Staged the sore as "2" with a length of 1.3 cm and width of 1.6 cm with no tunneling, exudate or pain.  * 10/18/10 - Has "Resolved" written across the line.</p> <p>The resident's "Non-Pressure Wound and Skin Condition Documentation Form" for the 10/22/10 sore documented that the sore was a "Stress Tear" on the resident's "Buttocks" area and no other documentation gave a description of exactly where it was located. The documentation for the "Buttocks" was:  * 10/22/10 - Classified as "Other" with a length of 3 cm by 0.6 cm with no tunneling, exudate or pain.  * 10/29/10 - Classified as "Other" with a length of</p>	F 314		

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F 314	<p>Continued From page 36</p> <p>2 cm by 0.6 cm with no tunneling, exudate or pain. * 11/5/10 - Classified as "Other" with a length of 1.8 cm by 0.5 cm with no tunneling, exudate or pain. * 11/8/10 - Classified as "Other" with a length of 0.6 cm by 0.2 cm with no tunneling, exudate or pain. * 11/18/10 - "Resolved."</p> <p>The resident's "Non-Pressure Wound and Skin Condition Documentation Form" for the 12/27/10 sore documented that the sore was on the "R [right] Ischial" area but no other documentation gave a description of exactly where it was located. The documentation for the "R Ischial" was: * 12/27/10 - Classified as an "Abrasion" with a length of 1.0 cm by 1.0 cm with 100% granulation and no tunneling, exudate or pain. * 1/10/11 - Classified as an "Abrasion" with a length of 1.0 cm by 1.0 cm with 10% granulation and no tunneling, exudate or pain. * 1/20/11 - Classified as an "Excoriation" with a length of 3.0 cm by 2.0 cm with 100% epithelial and no tunneling, exudate or pain. * 1/27/11 - Classified as an "Excoriation" with a length of 2.8 cm by width of 1.1 cm and a depth of 0.2 cm. The area had 100% slough tissue present, small amount of serious/sanguinous exudate and no tunneling or pain.</p> <p>The resident's care plans were reviewed. The care plan, with a print date of 3/9/10, documented for "Skin Care Plan: [Resident #4] is at risk for skin breakdown related to his impaired mobility and incontinence," and on 3/5/10 "excoriation to coccyx" was added. The interventions were: ** Cleanse perineal area well with each</p>	F 314		

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

PRINTED: 02/16/2011  
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  02/04/2011	
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 37</p> <p>incontinence episode.</p> <ul style="list-style-type: none"> <li>* Barrier cream to peri area as needed.</li> <li>* [Resident #4] has a maxifloat mattress in place to reduce pressure also has cushion in wheelchair.</li> <li>* Keep skin clean and dry.</li> <li>* [Resident #4] has soft heel lift boots to bilateral lower extremity when he is in bed to prevent pressure. He also has a bed cradle to the foot of his bed to prevent additional pressure."</li> </ul> <p>The care plan, with a print date of 6/26/10, documented for "Skin Care Plan: [Resident #4] is at risk for skin breakdown related to his impaired mobility and incontinence" and on 10/11/10 was added "Stage 2 pressure ulcer x 2 to coccyx." The interventions were the same as the 3/5/10 care plan. The maxifloat mattress was discontinued on 10/11/10 and a "Low airloss mattress with bolster sheet to promote skin integrity and offload pressure" was added.</p> <p>The care plan, with a print date of 10/27/10, documented "Skin Care Plan: [Resident #4] is at risk for skin breakdown related to his impaired mobility and incontinence." The interventions were:</p> <ul style="list-style-type: none"> <li>** Cleanse perineal area well with each incontinence episode.</li> <li>* Barrier cream to peri area as needed.</li> <li>* Keep skin clean and dry.</li> <li>* [Resident #4] has soft heel lift boots to bilateral lower extremity when he is in bed to prevent pressure. He also has a bed cradle to the foot of his bed to prevent additional pressure.</li> <li>* Assure foot rest removed during transfers to and from wheelchair.</li> <li>* Record percentage of meal consumed.</li> <li>* Cushion to wheelchair to promote skin</li> </ul>	F 314		

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

PRINTED: 02/16/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135107</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/04/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>IDAHO FALLS CARE &amp; REHABILITATION CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3111 CHANNING WAY IDAHO FALLS, ID 83404</b>		
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F 314	<p>Continued From page 38 integrity/offload pressure. * Weekly Skin check. * Treatments/Dressings to coccyx as ordered by the MD. * Low-air loss mattress with bolsters x 2 to promote skin integrity/offload pressure. * Treatments/Dressings as ordered by MD. * Soft hand braces (palm protectors) to bilateral hands at all times to promote skin integrity. * Foot cradle to bed to promote skin integrity/off load pressure."</p> <p>The current care plan, with a print date of 1/10/2011, documented, "Skin Care Plan: [Resident #4] is at risk for skin breakdown related to his impaired mobility and incontinence." The interventions were the same as the 10/27/10 care plan with the addition of: ** Excoriation to Right ischial will resolve without complication. * Roho cushion to wheelchair to off load pressure and promote skin integrity."</p> <p>The resident care plan failed to have any interventions for repositioning the resident.</p> <p>The facility had been completing a "Norton Plus Pressure Ulcer Scale" on the resident. The "Total Norton Plus Score (Score 10 or less = High Risk.) The resident had scored less than 10 all of 2010. The scores were: 3/18/10 = 5, 3/20/10 = 7, 9/6/10 = 5, 10/11/10 = 3, and 12/27/10 = 5.</p> <p>The resident's current sore was not visualized by the surveyor. The wound RN was asked on two occasions, 2/1/11 and 2/3/11, to look at the sore with the next dressing change and did not comply with the request. CNA#1 and CNA #2 were observed providing incontinence care, on 2/1/11</p>	F 314		

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

PRINTED: 02/16/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135107</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/04/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>IDAHO FALLS CARE &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3111 CHANNING WAY IDAHO FALLS, ID 83404</b>	
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F 314	<p>Continued From page 39</p> <p>at 8:55 a.m., and the location of the dressing covering the sore was observed. The dressing was located on the right lower area of the buttock near the ischial tuberosity. A "Nursing Assessment," dated 3/20/10, documented a "reddened" area in the resident's right lower buttocks in about the same location as the one the facility was currently treating.</p> <p>The sore on the right ischium was cultured on 1/31/11 and the gram stain came back with "1+ white blood cells, 4+ gram positive cocci, 4+ gram negative rods, and 3+ gram positive rods." The final results were not available by the end of the survey.</p> <p>On 2/2/11, the resident went to the wound clinic for the sore on the right ischium. The documentation from the wound clinic was not available at time of survey. The information provided via fax following the survey was only the physician's orders for treatment and there was no documentation of what was done at the visit or status of the wound.</p> <p>A review of the resident's "Comprehensive Metabolic Panel," dated 2/4/11, indicated the residents labs were within acceptable parameters, except for BUN, AST, ALT and HDL cholesterol. Nutritional parameter of Albumin, Total Protein, Glucose and Hgb A1c were all within acceptable parameters.</p> <p>On 2/3/11 at 10:30 a.m. the DON was interviewed about the two stage II sores on the coccyx and the current sore on the ischium. She indicated that the resident was nutritionally compromised and the sores were unavoidable. She also indicated the December sore was an abrasion</p>	F 314		

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

PRINTED: 02/16/2011  
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  02/04/2011	
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 40</p> <p>caused by his adult briefs. The DON did not have an explanation of why the documentation for the sores failed to clearly identify the locations and response to treatments.</p> <p>The resident was harmed due to the facility's failure to:</p> <ul style="list-style-type: none"> <li>* care plan the frequency of repositioning to prevent pressure to the buttocks/coccyx area.</li> <li>* prevent the return of excoriation to the resident's buttocks over the past year.</li> <li>* prevent Stage II pressure sores from occurring in October 2010 when the resident became ill and required placement of a feeding tube.</li> <li>* accurately identify location and response to treatments for excoriations and open sores.</li> <li>* investigate the cause of a "stress tear" in October 2010.</li> <li>* investigate the cause for the sore that occurred in December 2010, grew substantially in size, failed to heal.</li> </ul> <p>The administrator and DON were informed on 2/3/11 at 3:30 p.m. Further information received via fax after the survey had already been reviewed at the time of the survey.</p> <p>2. Resident #3 was admitted to the facility on 10/7/10 with diagnoses which included a Stage III pressure ulcer (PU) to buttocks, coronary artery disease, peripheral vascular disease, edema, osteomyelitis, hypertension, and diabetes mellitus.</p> <p>The resident's admission MDS assessment, dated 10/14/10, coded:</p> <ul style="list-style-type: none"> <li>* 1 unstageable PU covered with eschar, present at admission, 4 venous and/or arterial ulcers, and diabetic foot ulcer(s)</li> </ul>	F 314		

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

PRINTED: 02/16/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135107</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/04/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>IDAHO FALLS CARE &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3111 CHANNING WAY IDAHO FALLS, ID 83404</b>	
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F 314	<p>Continued From page 41</p> <ul style="list-style-type: none"> <li>* Cognitively intact</li> <li>* Extensive assistance by 1 person for bed mobility, transfers, walking in corridor, locomotion, toilet use, personal hygiene, and bathing; extensive assistance by 2 persons for dressing; does not walk in room; and uses both walker and wheelchair for mobility</li> <li>* Frequently incontinent of bowel and bladder</li> </ul> <p>The CAA associated with the 10/14/10 MDS assessment documented: "Skin CAA triggered by fact that resident is incontinent of bowel and bladder, by fact that she requires assist for bed mobility and by fact that she has multiple skin breakdown issues. She is alert and able to make her needs known. She is on a toileting program. Dietary, therapy and nursing have assessed."</p> <p>The resident's most recent quarterly MDS assessment, dated 1/14/11, coded:</p> <ul style="list-style-type: none"> <li>* 1 Stage III PU covered with slough, 1 healed Stage IV PU present on the prior assessment, 3 venous and/or arterial ulcers present, and diabetic foot ulcer(s)</li> <li>* Cognitively intact</li> <li>* Extensive assistance by 1 person for bed mobility, transfers, dressing, toilet use, and personal hygiene; does not walk in room or corridor; and uses wheelchair for mobility</li> <li>* Occasionally incontinent of bowel and bladder</li> </ul> <p>The resident's 1/28/11 skin wound care plan documented the following interventions:</p> <ul style="list-style-type: none"> <li>* "Pressure relieving cushion in wheel chair to promote skin integrity and offload pressure", initiated 10/7/10 and revised on 10/22/10.</li> <li>* "Weekly skin assessments,"</li> <li>"Treatments/dressing per MD," and "Float heels as ordered," each initiated 10/7/10.</li> <li>* "Podus boot to right foot at all times," initiated</li> </ul>	F 314		

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

PRINTED: 02/16/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135107</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/04/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>IDAHO FALLS CARE &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3111 CHANNING WAY IDAHO FALLS, ID 83404</b>		
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F 314	<p>Continued From page 42 1/14/11.</p> <p>NOTE: The care plan did not contain interventions ordered by the wound clinic (listed in the following wound-specific sections), and was not modified or individualized when PUs developed.</p> <p>The resident's medical record contained many entries in which her multiple wounds were referred to with varied nomenclature or terminology (i.e.: "left ischium", "left sacral", "coccyx", and "buttocks" were all used to refer to the left sacral Stage III PU which the resident had at admission to the facility). To reduce confusion and provide consistency, the wounds will be identified in this report as:</p> <ul style="list-style-type: none"> <li>* Wound A - Left sacral Stage III PU</li> <li>* Wound B - Various left foot/toe diabetic ulcers</li> <li>* Wound C - Right foot/shin/achilles area PU</li> <li>* Wound D - Right malleolus PU</li> <li>* Wound E - Right and left heel PUs</li> <li>* Wound F - Left dorsal 2nd toe, documented to be a PU and a diabetic wound</li> </ul> <p>Wound A (sacral):</p> <ul style="list-style-type: none"> <li>* Interdisciplinary Progress Notes (IPN) documented descriptions of this wound as lower back (10/7/10); left buttock (10/7/10); left sacral/sacrum (10/8/10, 10/9/10, 10/14/10, 10/26/10, 11/10/10, 11/23/10, 12/29/10); and coccyx (10/11/10, 12/20/10, 1/5/11, and in multiple entries from 1/19/11-2/1/11).</li> <li>* Non-Pressure Wound and Skin Condition Documentation Forms documented weekly measurements and descriptions, 10/12/10-1/26/11</li> <li>* Progress Notes by the resident's Physician Assistant documented descriptions of this wound as sacral (11/5/10, 11/15/10, 12/6/10, 12/9/10,</li> </ul>	F 314			

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

PRINTED: 02/16/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135107</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/04/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>IDAHO FALLS CARE &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3111 CHANNING WAY IDAHO FALLS, ID 83404</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 43 12/17/10, 12/21/10, 12/27/10, and 1/4/11); coccyx (11/24/10); buttocks (11/24/10); Stage III PU with no specific location (10/19/10, 10/28/10, 11/4/10); a WoundVac without specific location (10/26/10); and general osteomyelitis (12/15/10 and 1/17/11). * Medical Nutrition Therapy Assessments documented: Stage III and Stage II without specific locations (10/12/10); Stage III buttocks; unstageable coccyx PU, and left sacral Stage IV (1/5/11). NOTE: The document was dated 1/5/10, but as evidenced by referenced laboratory results, was actually written 1/5/11. * The 10/7/10 admission Nursing Assessment included an anatomical diagram with a circle drawn over the left sacral area, which was labeled to indicate that a dressing was in place. * The 1/9/11 quarterly Nursing Assessment included an anatomical diagram with a circle drawn over the left sacral area, which was labeled: "#5" (unstageable per the diagram's instructions); the words "bed sore" had a line drawn through them, followed by "[with WoundVac]". * Wound clinic records documented Physician Orders and Treatment Plans: Wheelchair Cushion - high profile Roho cushion needs to be ordered for patient and used in all seated situations (10/7/10 and 10/18/10); keep weight off affected area/limb at all times, limit sitting time, must shift sitting weight every 15 minutes or get out of chair onto bed (10/25/10); keep weight off affected area/limb at all times, seat lifts or shift position in chair every 15 minutes, turn every 2 hours, avoid position directing pressure to wound site, limit side lying to 30 degree tilt, limit head of bed elevation to 30 degrees in bed (11/1/10); and keep weight off affected area/limb at all times (11/17/10 and 11/29/10).	F 314		

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

PRINTED: 02/16/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135107</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/04/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>IDAHO FALLS CARE &amp; REHABILITATION CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3111 CHANNING WAY IDAHO FALLS, ID 83404</b>		
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F 314	<p>Continued From page 44</p> <p>Wound B (left foot diabetic ulcers):</p> <ul style="list-style-type: none"> <li>* IPN documented descriptions of these wounds as left foot (10/7/10, 10/8/10); inside of left foot (10/7/10); toes (10/7/10); left foot medial area (10/9/10); and left lateral 5th metatarsal head (10/9/10). IPN documentation did not describe the wounds as "diabetic," "vascular," or "pressure."</li> <li>* Non-Pressure Wound and Skin Condition Documentation Forms documented wound assessments for the left dorsal 2nd toe (1/24/11); left medial arch (11/12/10-12/6/10); and left lateral 5th toe (10/12/10-1/24/11).</li> <li>* Progress Notes by the resident's Physician Assistant documented descriptions of these wounds as left foot (10/14/10, 10/28/10); and left hallux (10/26/10, 12/17/10).</li> <li>* IPN documented treatments: left foot in a brace/boot - wound on inside of left foot and across toes covered with a [dressing] up to her leg (10/7/10); and post-op walking boot to left foot (10/9/10).</li> <li>* Progress Notes by the resident's Physician Assistant documented treatments: ankle boot on her left ankle (10/26/10); walking boot on her left foot (10/28/10)</li> <li>* Wound clinic records documented the wound on the left dorsal 2nd toe as a PU on 1/10/11 and 1/17/11, then as a diabetic ulcer with bone exposed on 1/24/11 and 1/31/11.</li> <li>* Wound clinic records documented Physician Orders and Treatment Plans: custom felt orthotic to the left lateral foot, leave orthotic felt in place at this time (10/7/10 and 10/18/10); felt orthotic to left medial foot and podus boot, keep weight off affected area/limb at all times (10/25/10); keep weight off affected area/limb at all times, cast shoe, avoid position directing pressure to wound site (11/1/10); keep weight off affected area/limb at all times, use podus boots on both lower</li> </ul>	F 314		

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

PRINTED: 02/16/2011  
FORM APPROVED  
OMB NO. 0938-0391

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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	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	<p>Continued From page 45</p> <p>extremities to prevent heel pressure, examine feet daily at skilled nursing facility to prevent PU (1/17/10 and 11/29/10); continue felt cutout to medial left foot (12/13/10); felt orthotic left second and fifth toe, also apply crow walking boot when patient is up throughout the day, and podus boot only at night (1/10/11); and cast boot left lower extremity (1/31/11).</p> <p>Wound C (right foot/shin/achilles area): * The 10/7/10 admission Nursing Assessments documented a skin/wound condition present; on the anatomical diagrams to indicate ulcers/skin conditions, the right foot was not circled, but had the word "boot" written beneath it. On a diagram of only the feet, the entire right foot was circled. An illegible note was hand written beside the right foot. * IPN documented descriptions of this area as "big black boot on right foot, skin intact" (10/7/10); dressing change to right foot (10/9/10); new orders received to use podus boot at all times to right foot to promote skin integrity (11/18/10); and "late entry for 1/10/11 - area to right foot resolved by [hospital] wound clinic. No open areas noted. Treatment discontinued" (1/11/11). * Progress Notes by the resident's Physician Assistant documented kind of a hard cover on her right lower extremity (10/26/10); hard cover on her right lower extremity (10/28/10); "she has developed a wound on her right lower shin. She has been wearing kind of a boot.... The treatment nurse has evaluated her and... has recommended that the prosthetic and orthotic company come and evaluate her boot and also move her wound care appointment up to this week rather than for two weeks.... She does have an excoriated area to her shin. There is some full thickness breakdown of her skin.... Right achilles skin</p>	F 314		

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

PRINTED: 02/16/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135107</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/04/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>IDAHO FALLS CARE &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3111 CHANNING WAY IDAHO FALLS, ID 83404</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 314	<p>Continued From page 46</p> <p>wound" (11/15/10); "She also has developed a sore on her right achilles area.... [The wound clinic] has recommended a podus boot on her foot at all times.... She does have the right achilles area wound" (11/24/10); "She also has developed a right achilles wound" (12/21/10); and "right foot wound" (1/17/11).</p> <p>NOTE: Investigative Guidelines define Stage III PU as, "Full thickness tissue loss."</p> <p>* Non-Pressure Wound and Skin Condition Documentation Forms documented wound assessments for the right achilles area (11/16/10, 12/16/10, 12/22/10, and 1/11/11).</p> <p>* Wound clinic records documented the following Physician Orders and Plans: keep weight off affected area/limb at all times. Use podus boots on both lower extremities to prevent heel pressure. Examine feet daily at skilled nursing facility to prevent PU (11/17/10 and 11/29/10); apply crow walking boot when patient is up throughout the day, and podus boot only at night (1/10/11); and multipodus boot right lower extremity (1/31/11).</p> <p>Wound D (right malleolus):</p> <p>* IPN documented descriptions of this wound as, "open area excoriation to right malleolus.... [Wound clinic] notified" (1/14/11).</p> <p>NOTE: Wound clinic documentation did not include reference to this wound, although the resident had an appointment for it on 1/17/11.</p> <p>* Wound clinic records documented the following Physician Orders and Plans: multipodus boot right lower extremity (1/31/11).</p> <p>* Progress Notes by the resident's Physician Assistant documented as "right foot wound" (1/17/11).</p> <p>* An Incident/Accident report for Resident #3 documented an "Event" on 1/14/11 at 2:30 PM.</p>	F 314			

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

PRINTED: 02/16/2011  
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  02/04/2011
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 47</p> <p>"Noted abrasion/excoriated area to right malleolus (sic) of foot. Small amount sero-sangous (sic) drainage noted. Resident recently started wearing crow walking boot to right foot again for stability with transfers. Appears boot rubbed on area.... Resident podus boot placed. Care plan updated. "Resident has no sensation in lower extremities and was unaware of area.... Resident recently started wearing her 'crow' walking boot to her right foot. Boot rubbed on the outer aspect of residents (sic) foot causing abrasion area. Removed boot, placed podus boot. Resident to see podiatrist at wound clinic on 1/17/11."</p> <p>NOTE: Investigative Guidelines define Stage II PU as, "Partial thickness loss of dermis presenting as a shallow open ulcer... [or] an intact or open/ruptured blister."</p> <p>Wound E (left and right heels):</p> <ul style="list-style-type: none"> <li>* IPN documented descriptions for this wound as open area to right heel.... called [orthotic specialist] to come and evaluate area / boot fitting (11/15/10); and open area excoriation to right malleolus.</li> <li>* Wound clinic records documented the following PUs developed while the resident was at the facility: <ul style="list-style-type: none"> <li>- PU on an (unspecified) heel, developed as Stage III on 11/17/10 and resolved on 1/3/11</li> <li>- PU on the right heel lateral plantar, developed on 1/3/11 and resolved on 1/10/11</li> </ul> </li> <li>* Wound clinic records documented that the following heel wounds were diabetic: <ul style="list-style-type: none"> <li>- "Posterior heel" (unspecified left or right), from 9/1/10 until it resolved on 9/8/10</li> <li>- "Right heel plantar", developed 1/17/11 and still present 1/31/11</li> </ul> </li> <li>* Wound clinic records documented the following</li> </ul>	F 314		

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

PRINTED: 02/16/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135107</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/04/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>IDAHO FALLS CARE &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3111 CHANNING WAY IDAHO FALLS, ID 83404</b>	
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F 314	<p>Continued From page 48</p> <p>Physician Orders and Plans: keep weight off affected area/limb at all times. Use podus boots on both lower extremities to prevent heel pressure. Examine feet daily at skilled nursing facility to prevent PU (11/17/10 and 11/29/10); apply crow walking boot when patient is up throughout the day, and podus boot only at night (1/10/11); and multipodus boot right lower extremity (1/31/11).</p> <p>Wound F (left dorsal 2nd toe): * Non-Pressure Wound and Skin Condition Documentation Forms documented 1 wound assessment for the left dorsal 2nd toe (1/24/11). * Wound clinic records documented the wound on the left dorsal 2nd toe as a PU on 1/10/11 and 1/17/11, then as a diabetic ulcer with bone exposed on 1/24/11 and 1/31/11.</p> <p>The 10/7/10 admission Nursing Assessment documented a Norton Plus PU Scale. The resident scored: Physical condition: Fair (3); Mental state: Alert (4); Activity: Chair bound (2); Mobility: Slightly limited (3); Incontinence: Occasional (3). Two points were deducted because the resident had a diagnosis of diabetes and took 5 or more medications. The total score was 13, where less than 10 indicated high risk, and 11-15 indicated moderate risk.</p> <p>NOTE: Based on the resident's 10/14/10 admission MDS assessment, the resident should have scored: Physical condition: Poor (2); Mental state: Alert (4); Activity: Walks with help (3); Mobility: Very limited (2); Incontinence: Double incontinence (1). Three points should have been deducted because the resident had diagnoses of diabetes and hypertension, and took 5 or more medications. The total score should have been 9 (high risk).</p>	F 314		

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

PRINTED: 02/16/2011  
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  02/04/2011
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	Continued From page 49  The 1/9/11 quarterly Nursing Assessment documented skin/wound conditions present, with associated pain; and a Norton Plus PU Scale. The resident scored: Physical condition: Fair (3); Mental state: Alert (4); Activity: Chair bound (2); Mobility: Slightly limited (3); Incontinence: Usually urine (2). Three points were deducted because the resident had diagnoses of diabetes and hypertension, and took 5 or more medications. The total score was 11 (moderate risk). NOTE: Based on the resident's 1/14/11 quarterly MDS assessment, the resident should have scored: Physical condition: Poor (2); Mental state: Alert (4); Activity: Chair bound (2); Mobility: Very limited (2); Incontinence: Double incontinence (1). Three points should have been deducted because the resident had diagnoses of diabetes and hypertension, and took 5 or more medications. The total score should have been 8 (high risk).  The DON was advised of the findings on 2/3/11 at 10:30 AM. She acknowledged that the interventions recommended by the wound clinic were not included on the resident's care plan, and stated that she would seek clarification on wound nomenclature from the wound clinic. On 2/3/11 at 3 PM, she provided a note from the wound clinic, which documented: "To clarify the wound care documentation, wound #12 is a diabetic ulcer. There is only one wound on the [patient's] buttocks, wound #7 is left sacral. References to the ischium is (sic) an error."  The wound care nurse and DON accompanied a surveyor to the resident's room for a skin assessment on 2/3/11 at 2 PM. The resident's bilateral lower extremities were bandaged, and	F 314		

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

PRINTED: 02/16/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135107</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/04/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>IDAHO FALLS CARE &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3111 CHANNING WAY IDAHO FALLS, ID 83404</b>	
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F 314	<p>Continued From page 50</p> <p>the bandages were not removed; the resident's hip areas did not have any indicators of PUs; and the WoundVac and dressing were observed to be intact to the resident's left sacrum. The DON and wound nurse were asked to describe and clarify the resident's current wounds, because the medical record had so much varied nomenclature. The wound nurse stated:</p> <ul style="list-style-type: none"> <li>* Wound A was the wound on the resident's left sacrum, which had a WoundVac present. It was also the "left ischial" and "coccyx" wound.</li> <li>* Wound B - "Both big toes have been removed", and the resident did not have a "left medial navicular" diabetic wound as described in the wound clinic documentation. Several of the previously documented diabetic ulcers had resolved. NOTE: The wound nurse was unfamiliar with the term "navicular", which the surveyor described anatomically and pointed to the top of the foot near the ankle. The wound nurse did not know whether the "left dorsal 2nd toe" wound was diabetic or pressure related. The resident then pointed to her left toes and stated, "that's where they took my bone out," which the wound nurse confirmed.</li> <li>* Wound C - she was unfamiliar with the documented "right achilles" wound, "unless they're calling it the same" as Wound D.</li> <li>* Wound D - that "right outer foot" was "the same as the malleolus," and she described the "right malleolus" as, "the outside of the foot, lateral, and it's [got an] open [wound] on the right."</li> <li>* Wound E - the wound nurse was unfamiliar with any heel wounds. The resident stated that she did have a right heel wound. NOTE: Wound clinic records documented a right heel diabetic wound still present as of 1/31/11.</li> </ul> <p>On 2/3/11 at 3:20 PM, the DON stated that the</p>	F 314		

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

PRINTED: 02/16/2011  
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  02/04/2011
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 51</p> <p>facility's wound care nurse was, "Just starting; she wants to get started (as a wound care nurse); she is fresh out, and she has a great interest in skin. She goes with the residents to the wound clinic." When asked whether the wound care nurse was a recently graduated RN, the DON stated that she was not, but that she was new to wound care.</p> <p>On 2/7/11, the facility faxed surveyors a letter from Resident #3's physician, which concluded: "It is my opinion that further skin breakdown is unavoidable." No further information was provided.</p> <p>Resident #3 developed the following PU while at the facility. Interventions ordered by the wound clinic were not added to the care plan; the care plan was not modified to adequately protect the resident from developing PU. The facility's wound care nurse was unfamiliar with several of the resident's wounds, although the DON stated that the wound care nurse accompanied residents to the wound clinic. The resident experienced pain associated with her wounds.</p> <p>* Wound C - "Full thickness breakdown"; Stage III per Interpretive Guidelines, although also documented as "an excoriated area" by the Physician's Assistant.</p> <p>* Wound D - "open area excoriation"; Stage II per Interpretive Guidelines.</p> <p>* Wound E - "open area right heel", "Stage III" on unspecified heel, and unstaged "right heel lateral plantar".</p> <p>* Wound F - initially considered a PU, later amended to a diabetic wound by the wound clinic.</p> <p>3. Resident #13 was admitted to the facility on 2/5/01, and readmitted on 1/1/10, with diagnoses</p>	F 314			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135107</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/04/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>IDAHO FALLS CARE &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3111 CHANNING WAY IDAHO FALLS, ID 83404</b>		
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F 314	<p>Continued From page 52</p> <p>which included congestive heart failure, edema, muscular wasting and disuse atrophy, and restless leg syndrome.</p> <p>The resident's most recent annual MDS assessment, dated 1/1/10, coded:</p> <ul style="list-style-type: none"> <li>* Total dependence on staff, with 2 or more staff physical assistance required for bed mobility, transfers, and toilet use</li> <li>* Indwelling catheter</li> <li>* Occasionally bowel incontinent</li> <li>* At risk for developing PUs</li> <li>* Skin treatments which included pressure reducing devices for chair and bed, nutrition or hydration interventions, applications of ointments or medications other than to feet</li> </ul> <p>The CAA Worksheet associated with the 1/1/10 MDS assessment documented, "Skin CAA triggered by fact that resident requires assist for bed mobility and by fact that she is occasionally incontinent of stool. She is alert and oriented and able to make her needs known. She has primary [diagnosis] of morbid obesity. She is on a toileting plan. She does have skin breakdown in the folds of her skin which are treated with barrier cream [daily and as needed]."</p> <p>The resident's 1/28/11 care plan included the following:</p> <ul style="list-style-type: none"> <li>* Mobility: decreased mobility characterized by impaired positioning and locomotion related to weakness, obesity, and osteoarthritis (initiated 1/1/10, revised 1/1/10). Interventions included: "Encourage resident to position self when in bed/chair as she is able. The amount [the resident] is able to reposition is minimal, but encourage her to do the movement that she is able" (initiated 1/1/10 and revised on 1/28/11).</li> </ul>	F 314			

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

PRINTED: 02/16/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135107</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/04/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>IDAHO FALLS CARE &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3111 CHANNING WAY IDAHO FALLS, ID 83404</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	<p>Continued From page 53</p> <p>* Skin integrity: Actual/potential for alteration in skin integrity related to weakness, immobility, and diagnoses of iron deficiency anemia, hypothyroidism, obesity, and edema (initiated 1/1/10 and revised 1/28/11). Interventions included:</p> <ul style="list-style-type: none"> <li>- Heel protectors PRN (as needed), initiated 1/1/10 and revised 6/26/10</li> <li>- Cushion to wheelchair, initiated 1/1/10 and revised 6/26/10</li> <li>- Keep skin clean, dry, and free of irritants such as feces or urine, initiated 1/1/10 and revised 6/26/10</li> <li>- Special pressure reducing mattress: air overlay, initiated 1/1/10</li> <li>- Staff will assist to turn and reposition routinely and PRN, initiated 1/1/10</li> <li>- Skin assessments by licensed nurse weekly and PRN, initiated 1/1/10</li> <li>- Maintain safe environment to help prevent skin injuries, initiated 1/1/10</li> <li>- Re-educated resident on importance of lying down between meals, initiated 3/23/10</li> </ul> <p>NOTE: Investigative Guidelines document, "Effective prevention and treatment are based upon consistently providing routine and individualized interventions." Resident #13's interventions were not individualized or modified when PU developed. Skin integrity interventions were most recently modified 6/10/10.</p> <p>The resident's 7/18/10 quarterly Nursing Assessment documented:</p> <ul style="list-style-type: none"> <li>* Skin/wound condition present: no</li> <li>* Norton Plus PU Scale score of 14, where less than 10 indicated high risk, and 11-15 indicated moderate risk</li> </ul> <p>Progress notes by the resident's Physician</p>	F 314		

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

PRINTED: 02/16/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135107</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/04/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>IDAHO FALLS CARE &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3111 CHANNING WAY IDAHO FALLS, ID 83404</b>		
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F 314	<p>Continued From page 54</p> <p>Assistant documented: * 9/13/10 - "She has developed an area in her buttocks that is rather tender. They are wondering if there is maybe something related to her wheelchair positioning so occupational therapy is going to evaluate and treat her for wheelchair positioning. I have reviewed that through... the treatment nurse who has been doing regular skin care checks on her.... There is no specific lesion. It is more of an excoriation of her upper buttock. There is no open skin thickness breakdown or drainage or discharge.... Skin friction to her coccyx area." * 10/11/10 - "The treatment nurse noticed kind of an excoriated area to her gluteal fold on her right side. They are unsure what caused it.... She does have an excoriated area on her right gluteus and into the fold of her buttocks. There is no drainage or discharge. It is just mainly excoriated and inflamed. There is no full skin breakdown.... Right gluteal abrasion.... We will do a liquid skin protectant to the gluteal fold. She does have a small tear in between her buttocks which... the treatment nurse will continue to treat on an ongoing basis as needed until resolved." * 10/13/10 - "She continues to have an excoriated area in her gluteal folds. There is no specific full thickness breakdown. There is no drainage or discharge. Skin excoriation to her buttocks." NOTE: Investigative Guidelines define Stage I PU as, "An observable, pressure-related alteration of intact skin, whose indicators as compared to an adjacent or opposite area on the body may include changes in one or more of the following parameters... sensation (pain, itching); and/or a defined area of persistent redness;" Stage II is defined as, "Partial thickness loss of dermis...."</p> <p>The resident's 10/31/10 quarterly Nursing</p>	F 314			

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

PRINTED: 02/16/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135107</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/04/2011</b>
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F 314	<p>Continued From page 55</p> <p>Assessment documented:</p> <ul style="list-style-type: none"> <li>* Skin/wound condition present, and anatomical diagrams to indicate ulcers/skin conditions: not marked</li> <li>* Norton Plus PU Scale score of 13, where less than 10 indicated high risk, and 11-15 indicated moderate risk.</li> </ul> <p>The resident's 1/28/11 quarterly Nursing Assessment documented:</p> <ul style="list-style-type: none"> <li>* Skin/wound condition present, and anatomical diagrams to indicate ulcers/skin conditions: not marked</li> <li>* Norton Plus PU Scale score of 12, where less than 10 indicated high risk, and 11-15 indicated moderate risk</li> </ul> <p>Wound nurse progress notes documented:</p> <ul style="list-style-type: none"> <li>* 8/27/10 - "[Resident complained of] soreness to [right] ischium. Noted dry flaky skin [with] redness, [no] open areas. Area cleansed, cream applied."</li> <li>* 8/31/10 - "Noted redness to [right] gluteal fold.... Noted redness to base of [left] heel."</li> <li>* 9/21/10 - "Cream applied to buttocks [and] gluteal folds, redness to base of [left] heel."</li> <li>* 9/28/10 - "Cream applied to gluteal folds [and] buttocks, redness to base of [left] heel."</li> <li>* 10/5/10 - "Noted to have scratches to buttocks [right]. Staff report seeing [resident] scratching self. [Resident] noted to have dried blood to fingernails. Fingernails filed. [Resident] noted to have excoriation to [left and right] gluteal fold. Cream applied. [No] other skin issues noted."</li> <li>* 10/5/10 - "Addendum to 10/5/10. [Resident] also noted to have stress tear to area between buttocks."</li> <li>* 10/11/10 - "Noted excoriation to back of upper thigh."</li> </ul>	F 314		

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

PRINTED: 02/16/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135107</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/04/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>IDAHO FALLS CARE &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3111 CHANNING WAY IDAHO FALLS, ID 83404</b>	
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F 314	Continued From page 56 NOTE: Investigative Guidelines definitions include: "A pressure ulcer is any lesion caused by unrelieved pressure that results in damage to the underlying tissue(s). Although friction and shear are not primary causes of pressure ulcers, friction and shear are important contributing factors to the development of pressure ulcers.... Shear occurs when layers of skin rub against each other or when the skin remains stationary and the underlying tissue moves and stretches and angulates or tears the underlying capillaries and blood vessels causing tissue damage."  Interdisciplinary Team notes from 7/29/10-12/3/10 were reviewed. The only mention of skin concerns was on 12/3/10, for an unrelated issue.  Resident #13's care plan was not modified to reflect or intervene for actual and potential PUs. She was documented to be at moderate risk for developing PUs, and developed PUs which included: * Right ischium redness * Gluteal fold redness * Left heel redness * Buttocks "stress tear" * Posterior upper thigh excoriation  The DON was advised of the findings on 2/3/11 at 1:30 PM. On 2/3/11 at 3:25 PM, she provided several documents referenced above, and stated, "That's all I had."	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER  Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the	F 315	<b>F315</b> <b>Corrective actions for residents affected:</b> Resident #6's physician was contacted by the licensed nurse and the indwelling catheter was discontinued on 2/21/11.	

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

PRINTED: 02/16/2011  
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  02/04/2011
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F 315	<p>Continued From page 57</p> <p>resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure residents had medical justification for an indwelling catheter left in place for an extended period of time. This was true for 1 of 3 residents sampled for indwelling catheters (#6). Findings include:</p> <p>Resident #6 was admitted to the facility on 5/15/09, and readmitted on 9/27/10, with diagnoses of polymyalgia rheumatica, diabetes mellitus type II, traumatic fracture of hip and personal history of fall.</p> <p>The resident's 8/5/10 annual MDS assessment documented the resident had no memory or communication problems, and required extensive assistance of 1 person for bed mobility, transfer, dressing and hygiene. The resident was assessed as having no loss or limitation in range of motion and was able to self propel in her wheelchair. No falls or fractures were documented and pain was rated as "0." The assessment for bladder continence was "3 = frequently incontinent" and pads, briefs used.</p> <p>Resident #6's toileting care plan, initiated 5/15/10, stated the resident required assistance with toileting related to a history of pelvic pain,</p>	F 315	<p><b>Identifying other residents having the potential to be affected, and what corrective action will be taken:</b> Resident's with catheters were re-evaluated by the Director of Nursing on 2/23/11 for diagnosis.</p> <p><b>Measures and systemic changes to prevent recurrence:</b> Licensed staff will be re educated on diagnosis for indwelling catheters by the Regional on or before 2/26/11. Residents with indwelling catheters will be reviewed initially during C.A.R.E. meeting and then quarterly for diagnosis.</p> <p><b>Monitoring Corrective Action for sustained corrections:</b> DNS or designee will complete a monthly audit for three months of residents with catheters to ensure appropriate review. Areas of concern will be addressed. POC &amp; audits will be reviewed by the facility Performance Improvement committee monthly for compliance &amp; trends and make recommendations as needed for 3 months or until resolved.</p> <p><b>Completion Date:</b> 3/2/2011</p>	

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

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OMB NO. 0938-0391

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F 315	<p>Continued From page 58</p> <p>deconditioning, and incontinence. The plan also stated the resident required a toileting program. Interventions included "[Resident #6] is occasionally incontinent of bowel and bladder and able to make her elimination needs known. Assist her as needed." and "Toilet upon awakening, before and after meals, at HS (hours of sleep) and prn (as needed.)"</p> <p>An I&amp;A report, dated 9/23/10, described a fall sustained by the resident at 6:25 a.m. on that date. The resident was readmitted to the facility on 9/27/10 after hospitalization for left intertrochanteric proximal femur fracture.</p> <p>Resident #6's 9/30/10 significant change MDS documented the resident had range of motion limitations to the leg, fell in the past 30 days and hip fracture in the past 180 days. The resident was assessed as requiring 2 person extensive assistance with mobility and transfers. Pain was evaluated as daily, horrible/excruciating at times. The MDS documented the use of an indwelling Foley catheter.</p> <p>On 10/8/10, the care plan was updated to include a Foley catheter plan related to a diagnosis of urinary retention.</p> <p>The most recent quarterly MDS assessment, dated 1/4/11, documented the resident had an indwelling catheter. Active diagnoses section failed to specify any urinary related diagnosis. The pain assessment section showed "0" for scheduled pain medication, prn pain medications and non- medication interventions for pain. The pain presence interview coded "0" = "No" for the question to the resident, "Have you had pain, or hurting at any time in the last 5 days?"</p>	F 315			

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

PRINTED: 02/16/2011  
FORM APPROVED  
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F 315	<p>Continued From page 59</p> <p>The resident's record included 3 Bowel and Bladder Continence Evaluations. The first, dated 8/12/10 - 8/16/10, indicated with a check mark that it was a bowel and bladder assessment, a quarterly evaluation, and stated the resident was usually incontinent of bowel and bladder related to a history of hip fracture, deconditioning and pain. The assessment stated the resident was on a scheduled voiding program.</p> <p>The next assessment was dated 9/27/10 - 10/3/10, and stated the resident had an indwelling Foley catheter.</p> <p>The most recent assessment was dated 10/9/10 - 10/15/10, and was not checked to indicate what type of assessment it was, i.e.. bowel, bladder or both bowel and bladder. The evaluation form stated "cath" (catheter), which was still in place at the time. "Scheduled voiding" was checked for the type of program in place, which would not be possible to initiate, as the resident had the indwelling catheter in place. No other bladder assessment information was present in the record.</p> <p>The DON and RN clinical consultant were interviewed on 2/3/11 at 10:20 a.m. The DON was asked if any documentation of clinical indication for continuation of the Foley catheter was present. No information was provided until 2/7/11, when a fax document was sent. The Physician Progress Notes document, dated 11/23/10, stated "**Foley cath[eter] still required."</p> <p>The interpretive guidance at F315 state in part, Indwelling Catheter Use - The facility's documented assessment &amp; staff approach to the</p>	F 315			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 315	Continued From page 60 resident should be based on evidence to support the use of an indwelling catheter. Appropriate indications for continuing use of an indwelling catheter beyond 14 days may include: o Urinary retention that cannot be treated or corrected medically or surgically, for which alternative therapy is not feasible, & which is characterized by: - Documented post void residual (PVR) volumes in a range over 200 milliliters (ml); - Inability to manage the retention/incontinence with intermittent catheterization; and - Persistent overflow incontinence, symptomatic infections, and/or renal dysfunction. o Contamination of Stage III or IV pressure ulcer with urine which has impeded healing, despite appropriate personal care for the incontinence; and o Terminal illness or severe impairment, which makes positioning or clothing changes uncomfortable, or which is associated with intractable pain.  The facility failed to provide the required documentation of clinical necessity for Resident #6's continued use of the indwelling Foley catheter.	F 315		
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.	F 323	<b>F323</b> <b>Corrective actions for residents affected:</b> The care plans for Resident #1 and #6 were reviewed by the DNS on or before 2/28/11 and updated to reflect current interventions for fall prevention.	

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

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F 323	<p>Continued From page 61</p> <p>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 prevent falls. This was true for 2 of 15 (#s 1 and 6) sampled residents and resulted in harm to Resident #1. *Resident #1, who was at high risk for falls upon admission, was harmed when she fell and sustained a nondisplaced fracture of her right femur/hip. The facility failed to implement interventions such as a low bed, a mat beside the bed or a plan for supervision upon admission. She suffered severe pain and loss of functioning related to the fracture. Four subsequent falls occurred without implementing increased supervision. *Resident #6 fell out of bed and sustained a hip fracture. The care planned intervention to maintain her bed in low position was not observed to be implemented. Findings include:</p> <p>1. Resident #1 was admitted to the facility on 9/23/10 with diagnoses of traumatic fracture of lower leg, personal history of fall, and dementia. The resident was readmitted to the facility on 10/8/10 after sustaining a fall which resulted in traumatic hip fracture in the facility on 9/27/10.</p> <p>Resident #1's 5 day Medicare MDS, dated 9/29/10, documented the resident experienced both short and long term memory problems, required limited 1 person physical assistance for toileting and bed mobility, extensive 1 person physical assistance for walking and transfer. The resident was assessed as having pain daily, sometimes horrible/excruciating. The assessment</p>	F 323	<p><b>Identifying other residents having the potential to be affected, and what corrective action will be taken:</b></p> <p>Residents residing in the facility have the potential to be affected. Residents at risk for falls have been identified by Director of Nursing on or before 2/27/11 and interventions have been put into place and care planned.</p> <p><b>Measures and systemic changes to prevent recurrence:</b> Events are reviewed at the Administrative morning meeting and placed on the clinical white board for follow-up to include new interventions, notification of physician and family, care plan update and care card update to ensure documentation is complete on the events. Approval was obtained from the state for the Regional Director of Clinical Operations to provide education to the facility staff. Staff were re-educated by the Regional Director of Clinical Operations on or before 2/26/11 on fall prevention, injury prevention and supervision to prevent falls. The training also covered the incident/accident process.</p>	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 323	<p>Continued From page 62</p> <p>stated the resident had fallen in the past 30 days and had a fracture (other than hip) in the past 180 days.</p> <p>A Resident Fall Evaluation, dated 9/23/10, indicated "Y" for yes on 12 of the 21 categories which were evaluated for risk status, such as falls within 30 days, pain, continence and mobility. The form, however, did not conclude a fall risk level, (high - low) and it was not clear how the evaluation directly resulted in fall prevention interventions on the resident's care plan.</p> <p>The resident's initial care plan for falls, dated 9/23/10, identified the risk of injury due to:</p> <ul style="list-style-type: none"> <li>* History of falls</li> <li>* Decline in strength with poor balance</li> <li>* Poor vision</li> <li>* Impaired judgment</li> <li>* Diagnosis of left tibial plateau fracture.</li> </ul> <p>The approaches to achieve the goal of "Be free from injury R/T [related to] falls" were, in part:</p> <ul style="list-style-type: none"> <li>* Fall prevention/restraints:</li> <li>* Star Gazer fall program (dated 9/23/10)</li> <li>* Alarms in bed (dated 9/23/10)</li> <li>* Alarms in wheelchair (dated 9/23/10)</li> </ul> <p>Note: The facility's Star Gazer Program policy was requested and reviewed. The program was available for residents meeting the criteria of falling within 30 days of admission, experiencing a change in condition, declining in gait/mobility, or falling in the facility. The program was in place for a minimum of 90 days after initiation, and longer if so determined by the IDT. No interventions accompanied the assessment to place a resident on the program with the exception of a star decal on the nameplate outside the resident's door and</p>	F 323	<p>Residents determined to be at high risk for falls upon admission will have interventions put into place at time of admission, which will be reviewed and discussed in clinical stand-up meeting with the interdisciplinary team to ensure documentation of the interventions on the care plan and CNA Care Card.</p> <p><b>Monitoring Corrective Action for sustained corrections:</b> The DNS/Designee will complete three audits weekly for three months of residents at risk for falls to ensure interventions/devices ordered are in place and care planned. The POC and audits will be reviewed monthly by the facility Performance Improvement committee for compliance &amp; trends and make recommendations as needed for 3 months or until resolved.</p> <p><b>Completion Date: 3/2/2011</b></p>	

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

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F 323	<p>Continued From page 63 on the wheelchair or other mobility device.</p> <p>The alarm in the resident's wheelchair was identified as a self releasing seat belt which sounded when unbuckled. The resident had been assessed as having the ability to release the seatbelt at will and on command according to an 11/15/10 OT progress note and as demonstrated to surveyor on 2/1/11 at 8:45 a.m.</p> <p>An Incident/Accident [I&amp;A] report, dated 9/27/10 at 9:20 p.m., documented the following: "Staff responded to resident crying and calling for help. Noted resident sitting up on the floor with her back leaning against the wall beside her bed. Resident states she sat up in bed to locate her call light when she slid out of the bed. Bed alarm in place, turned on but did not sound as it was not plugged into the alarm box. Resident c/o [complained of] right hip pain and would not move her right leg. MD and family notified. Orders received to send to ER [emergency room] to eval[uate] and treat. Resident sent to ER via ambulance. Resident returned from ER, no fractures noted on x-ray taken 9/27/10. CNA states resident's alarm was in place, turned on, plugged in and functioning when he checked on resident at 9:00 PM. On 9/30/10 resident continued to favor right leg and c/o pain MD notified - CT of right hip was ordered which revealed non-displaced intertrochanteric fracture proximal right femur/hip. Saw ortho [orthopedic physician] on 10/01/2010 - Admitted for ..." (Unable to read remainder of entry as electronic document was printed without the rest of the note on the screen.) Page 5 of the I&amp;A stated in an additional comment "...Appt. [appointment] with orthopedic surgeon was set up for 10/01/2010 at 10:45 a.m. and resident was admitted to hospital</p>	F 323		

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

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F 323	<p>Continued From page 64 for surgery."</p> <p>Under "Narrative conclusion of root cause", the report concluded the resident inadvertently unplugged the bed alarm when she was trying to find her call light.</p> <p>The report included documentation that Staff education was conducted after the fall, which included instruction to staff to make sure alarms were plugged in and functioning throughout the shift.</p> <p>Resident #1's care plan was modified on 9/27/10 to include: * High-Low bed * Cushion (mat) pads on floor.</p> <p>Interdisciplinary Progress Notes from nursing documented in part: 9/28/10 at (illegible time) Resident c/o pain in legs and back at a level of 4 to 5 on the pain scale. Also c/o pain and numbness in right arm. Medicated for the pain. 9/29/10 at (illegible time) Medicated for c/o of right hip pain. 9/30/10 at (illegible time) Medicated for c/o right hip pain. 9/30/10 at 8:10 p.m. New order, activity - non weight bearing, orthopedic consult as soon as possible, diagnosis of mildly displaced intertrochanter, 9/30/10 (illegible time) Resident in bed most of day due to right hip pain, medicated for pain times 2. No physical therapy that day. 10/1/10 4:00 a.m. Medicated once for pain. 10/1/10 (no time entered) Resident admitted to the hospital for right hip "fixation."</p>	F 323		

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

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FORM APPROVED  
OMB NO. 0938-0391

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F 323	<p>Continued From page 65</p> <p>According to an I&amp;A report, dated 10/12/10 at 9:45 p.m., Resident #1 sustained another unwitnessed fall. The report documented staff responded to the bed alarm sounding and found the resident laying on her right side on the mat next to her bed. The call light was reportedly in her hand but not activated. The resident had propped herself up on her right elbow with her neck resting on the wastebasket next to her bed. She was reportedly looking for her children. The resident complained at the time of the accident that her neck was sore. The report further stated that subsequent to the fall, her bed was moved against the wall and a body pillow placed in the bed for comfort and to define the edge of the bed. No other care plan interventions were put in place.</p> <p>On 11/11/10 at 9:00 p.m., the resident experienced another unwitnessed fall from bed to the mat on the floor at the bedside. No injuries were noted. The report included an intervention of bolsters on the mattress; however, the bolsters were not indicated on the care plan.</p> <p>On 11/17/10 at 10:10 a.m., the resident was again found on the floor of her room in a sitting position. The bed alarm had sounded, and the call light was within reach but not activated. The resident did not have signs of injury. The bolsters were discontinued, and a scoop mattress was put in place to "better define edge of bed." The report further stated the resident was on the physical and occupational therapy caseload at the time of the fall. No further care plan interventions were put in place.</p> <p>An Interdisciplinary Progress Note, dated 1/11/11, documented that at 10:45 a.m. the resident</p>	F 323			

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

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F 323	<p>Continued From page 66</p> <p>"undid her seat belt and went to stand up and had seizure activity and she was assisted to the floor. Did not hit head. Sent to ER to eval[uate] and tx [treat]."</p> <p>On 2/3/11 at 10:10 a.m., the DON was interviewed about the 1/11/11 incident. She stated no I&amp;A had been initiated for the event because the resident had been assisted to the floor by staff.</p> <p>According to an I&amp;A dated 1/29/11 at 4:15 p.m., staff responded to the resident's call for help. The resident was found on the floor in a sitting position between her wheelchair and the lounge chair in her room. According to the report, the resident's seat belt with alarm had been removed by the resident and fastened behind her in the seat. The facility's intervention was to send the resident to therapy for screening. No injury was apparent. No other care plan interventions were initiated. The report did not provide explanation on how the resident had disconnected the alarmed seatbelt, placed it behind her in the chair and reconnected it without having the alarm sound.</p> <p>The DON and RN clinical consultant were interviewed on 2/3/11 at 10:10 a.m. After a brief review of the resident's fall history, the DON was asked if the IDT had ever considered increased supervision as an intervention to prevent further falls. The DON stated the resident's falls were discussed in morning meeting. She further stated the resident was "impulsive" and "non-cooperative." It was reportedly difficult to ensure her safety because she could release the alarmed seat belt, and could remove a lap buddy restraint when it was placed on the wheelchair</p>	F 323		

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

PRINTED: 02/16/2011  
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  02/04/2011
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F 323	<p>Continued From page 67</p> <p>during a trial. No further information was provided during the interview on increasing supervision as an intervention to prevent falls for the resident.</p> <p>Resident #1 was admitted to the facility after a fall with fracture in the home setting. Within 4 days of admission, the resident sustained a fall which resulted in a hip fracture. The resident experienced 6 additional falls between the initial fall on 9/27/10 and 1/29/11. No evidence was present in the resident's record, or obtained through interview, that the facility had implemented increased supervision to prevent further harm to the resident.</p> <p>2. Resident #6 was admitted to the facility on 5/15/09, and readmitted on 9/27/10, with diagnoses of polymyalgia rheumatica, diabetes mellitus type II, traumatic fracture of hip and personal history of fall.</p> <p>The resident's 8/5/10 annual MDS assessment documented the resident had no memory or communication problems, required extensive assistance of 1 person for bed mobility, transfer, dressing and hygiene. The resident was assessed as having no loss or limitation in range of motion and was able to self propel in her wheelchair. No falls or fractures were documented and pain was rated as "0".</p> <p>Resident #6's fall care plan included interventions to place call light within easy reach, place necessary items within reach, 2 quarter side rails for bed mobility and work with therapy for optimal endurance and safety awareness.</p> <p>An I&amp;A report, dated 9/23/10, described a fall sustained by the resident at 6:25 a.m. on that</p>	F 323		

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

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FORM APPROVED  
OMB NO. 0938-0391

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F 323	<p>Continued From page 68</p> <p>date. The report stated, "Staff responded to resident crying and calling for help. Noted resident sitting up on the floor with her back leaning against her bed and her left leg tucked under her right leg. Call light was next to resident but not activated prior to incident. Resident states she sat up in bed to locate her call light when she slid out of bed. Resident states that her leg twisted and she fell on it and she thinks she broke it. Res[ident] assisted to supine position, resident c/o left hip pain. hip appears displaced. MD and family notified. Orders received to send to ER to eval[uate] and treat. Resident sent to ER via ambulance. Resident admitted to hospital with left hip fracture."</p> <p>The resident was readmitted on 9/27/10 after hospitalization for left intertrochanteric proximal femur fracture. Hospital records, dated 9/23/10 stated the resident was placed in Buck traction for pain control. A 9/28/10 Physician Progress Notes entry documented "...surgery not done due to multiple comorbid conditions and the fact that she has been non-ambulatory for 18+ months."</p> <p>Resident #6's 9/30/10 significant change MDS documented the resident had range of motion limitations to the leg, fell in the past 30 days and hip fracture in the past 180 days. The resident was assessed as requiring 2 person extensive assistance with mobility and transfers. Pain was evaluated as daily, horrible/excruciating at times.</p> <p>The fall care plan was updated on 9/23/10 as a result of the fall, to include, "Halo's" bilaterally to promote independence with bed mobility, scoop mattress to define edge of bed, bed alarm, referral to therapy and Star Gazer Program. The Halo's, scoop mattress and bed alarm were</p>	F 323		

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

PRINTED: 02/16/2011  
FORM APPROVED  
OMB NO. 0938-0391

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F 323	Continued From page 69 marked as "discontinued" on 9/23/10, the same date they were added to the care plan. On 9/27/10 "Hi-low bed in lowest position" was added.  An updated fall care plan, dated 10/8/10 and revised 1/14/11, contained the Star Gazer program, 1/4 side rails for bed mobility and Hi-low bed in lowest position.  Resident #6 was observed in bed on 1/31/11 at 7:00 p.m., on 2/1/11 at 8:45 a.m., 9:20 a.m., 10:00 a.m., 1:05 p.m. and 3:45 p.m. During all observations the bed was in a raised position, with the mattress approximately 40 inches from the floor.  On 2/2/11 at 7:30 a.m. the resident was observed in bed in the same raised position.  On 2/3/11 at 7:50 a.m. 2 surveyors observed the resident in bed and confirmed the bed to be in a raised position of approximately 40 inches from the floor.  The DON and RN clinical consultant were interviewed on 2/3/11 at 10:20 a.m. The DON was informed of the surveyor's observations of the resident in bed with the bed in raised position. The DON confirmed the care plan for Hi-low bed in low position was a current intervention for Resident #6's fall prevention. No further information was provided.	F 323		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS  The facility must ensure that residents are free of any significant medication errors.	F 333		

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

PRINTED: 02/16/2011  
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F 333	<p>Continued From page 70</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure that residents were free of significant medication errors. This was true for 1 of 13 sampled residents (#2) and 1 of 3 random residents observed during medication administration (#10). Resident #2 was supposed to receive 40 milligrams (mg) of Lasix intravenously (IV) on 11/15/10, but was administered only 20 mg. Resident #10 was administered Coreg 6.25 mg, when there was an order to hold it. Findings included:</p> <p>1. Resident #2 was admitted to the facility on 3/8/04, and readmitted on 12/1/08, with diagnoses which included acute respiratory failure, essential hypertension, and congestive heart failure.</p> <p>The resident's annual MDS assessment, dated 7/12/10, coded: no indicators of fluid status problems, diuretics received for 7 of the prior 7 days, and monitoring of acute medical condition.</p> <p>The resident's November 2010 Care Plan documented the focus, alteration in health: multiple cardiac diagnoses - congestive heart failure, edema, hypertension, and atrial fibrillation. Interventions included, "Medications as ordered."</p> <p>The resident's February 2011 Physician's Orders (recapitulation) documented orders for the resident to receive Lasix 80 mg orally every morning, and 40 mg orally at 4:00 PM every afternoon.</p>	F 333	<p><b>F333</b> <b>Corrective actions for residents affected:</b> Resident's #2 and #10 have been reassessed by the Director of Nursing on 2/23/11 for accuracy of physician orders and medication administration records (MAR'S). Resident #10's physician was notified on 2/1/11 by SDC for clarification. Resident #2's order was clarified on 11/15-10 by LN.</p> <p><b>Identifying other residents having the potential to be affected, and what corrective action will be taken:</b> A review of the resident physician orders has been completed by the Director of Nursing on 2-23-11 to ensure accuracy. Medications will be administered according to the physician orders.</p> <p><b>Measures and systemic changes to prevent recurrence:</b> Licensed nurses have been re-educated by the Regional Director of Clinical Operations on or before 2/26/11 on medication administration policies and procedures.</p>	

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

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F 333	<p>Continued From page 71</p> <p>Hand written Physician's Orders in the resident's medical record documented: * 11/15/10 - "Put in heplock run 40 of Lasix IV." NOTE: The order did not specify the unit measurement to administer. See next NOTE. * 11/15/10 - "Give 40 ml [milliliters] Lasix through IV." NOTE: Lippincott Williams and Wilkins' Nursing 2010 Drug Handbook documented that Lasix is only available in 10 mg/ml for injection. Standard dosage is 40 mg IV for acute pulmonary edema, and 20-40 mg IV for edema. The order as written was an error; 40 ml would be 400 mg, a tenfold overdose.</p> <p>A computer generated Pharmacy report documented the following order to start on 11/15/10: "Furosemide 40 mg/ml solution intravenous (IV) - One time only: Give 20 mg of medication stat. One time dose," for fluid retention. The order was noted by a licensed nurse on 11/15/10 and signed by the prescribing physician on 11/18/10. NOTE: This contradicted the telephone order. There were no other documented orders for 11/15/10.</p> <p>The resident's November 2010 MAR documented, "Furosemide - intravenous (IV), dose: 40 mg/ml.... Give 20 mg of medication stat. One time dose...." A licensed nurse initialed the MAR on 11/15/10, to document that the medication was administered.</p> <p>Interdisciplinary Progress Notes documented: * 11/14/10 at 11:58 AM - "[Decreased oxygen saturations] 70% on [2 liters of oxygen via nasal cannula].... Lung sounds diminished [with] noted crackles throughout."</p>	F 333	<p><b>Monitoring Corrective Action for sustained corrections:</b> DNS or designee will complete three audits weekly for three months of medication administration to ensure compliance. POCs and audits will be reviewed by the facility Performance Improvement Committee monthly for compliance &amp; trends and make recommendations as needed for 3 months or until resolved.</p> <p><b>Completion Date: 3/2/2011</b></p>

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

PRINTED: 02/16/2011  
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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 333	<p>Continued From page 72</p> <p>* 11/15/10 (no time) - "[Resident complained of] shortness of breath. [Oxygen saturation] 79%.... Received new orders to send to [hospital] for chest x-ray."</p> <p>* 11/15/10 (no time) - "[Doctor] called, asked to have hepllock placed and run 40 of Lasix IV."</p> <p>* 11/15/10 (no time) - "Lasix 20 mg IV [push] given over 10 minutes per order, [1] dose."</p> <p>* 11/16/10 (no time) - "Received new orders to give 40 ml (sic) Lasix IV...."</p> <p>The DON was interviewed about the findings on 2/3/11 at 10:35 AM. She stated that the Interdisciplinary Progress Notes which documented the physician's orders on 11/15/10 were "confirming the order, not for the resident to receive 2 doses on 11/15/10." Then she stated that resident got 20 mg on 11/15/10, and 40 mg on 11/16/10. When asked how the order for 40 mg got changed to 20 mg, she stated, "The hall nurse entry was incomplete. The charge nurse clarified the order; it was supposed to be 20 mg on the first dose order." When asked to provide documentation of the charge nurse's physician contact for clarification, the DON stated, "I don't know that [the charge nurse] wrote anything, he just entered it [into the computerized pharmacy program]. I'll have to check the nurse's notes on that. The next day we gave [the resident] 40 mg because the 20 mg didn't really do much." No further information was provided.</p> <p>2. Resident #10 was admitted to the facility on 1/24/11, with diagnoses which included congestive heart failure, atrial arrhythmias, and essential hypertension. An MDS assessment had not been completed at the time of survey.</p> <p>During a medication pass observation on 2/1/11</p>	F 333		

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

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FORM APPROVED  
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F 333	<p>Continued From page 73</p> <p>at 9:05 AM, LN #3 was observed to pass medications to Resident #10. LN #3 checked Resident #10's blood pressure (BP) and pulse, then administered Coreg 6.25 mg. Once the medication pass was complete, the surveyor checked Resident #10's medical record to verify medication orders.</p> <p>Physician's Orders (recapitulation) for February 2011 included: * Coreg 6.25 mg PO orally BID for atrial arrhythmia, "Hold if BP (blood pressure) is less than (sic) or equal to 11/70 (sic) or if pulse is less than (sic) or equal to 70," started 1/26/11. * Occupational and Physical Therapy, started 1/26/11.</p> <p>Physician's Orders (recapitulation) for January 2011 included: * Coreg 6.25 mg PO orally BID for atrial arrhythmia, started 1/24/11.</p> <p>Physician's Orders hand written between the January and February recapitulations included: 1/26/11 - "Hold Coreg if BP [less than or equal to] 110/70 or if pulse [less than or equal to] 70." 1/28/11 - "Hold Coreg [due to] orthostatic hypotension.... Hold therapy today [due to] nausea/vomiting." NOTE: The order specified to hold therapy for 1 day, but did not specify a length of time to hold the Coreg.</p> <p>Interdisciplinary Progress Notes for Resident #10 included: * 1/28/11 - "[At] 2:10 AM... checked resident's pulse, irregular [at] 65 rate, and heart sounds were irregular.... [At] 2:30 AM... Resident placed on left side and became lethargic. His hands and forearms, bilaterally, were pale, cold, and clammy</p>	F 333		

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

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NAME OF PROVIDER OR SUPPLIER  <b>IDAHO FALLS CARE &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3111 CHANNING WAY IDAHO FALLS, ID 83404</b>	
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F 333	Continued From page 74 with a... pulse 45.... [At] 4:30 AM... pulse 47 and irregular." * 1/30/11 - "[Resident] making more positive statements about his health. 'If I can get over being dizzy I can go home." NOTE: Lippincott Williams and Wilkins' Nursing 2010 Drug Handbook documented adverse reactions to Coreg which included: dizziness, fatigue, stroke, vertigo, somnolence, hypotension, postural hypotension, atrioventricular block, bradycardia, angina pectoris, chest pain, vomiting, and nausea.  The DON was informed of the findings on 2/1/11 at 10:00 AM. On 2/1/11 at 2 PM, the DON stated that Resident #10's physician assistant had, "wanted to hold [the Coreg] for 3 days and then restart it." She stated that the 3rd day was, "today, so we restarted it today." NOTE: The hold order was in effect at the time of the medication pass.  On 2/1/11 at 3:00 PM, the DON stated, "I clarified that [the Coreg hold parameter] was supposed to be 110/70, not 11/70."  Resident #10 experienced significant bradycardia, cardiac arrhythmia and orthostatic hypotension in the facility, for which an order to hold his Coreg was written. The medication was administered after the hold order, which placed the resident at risk for recurrent cardiac problems.	F 333		
F 353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS  The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and	F 353	<b>F353</b> <b>Corrective actions for residents affected:</b> Resident #1's plan of care was updated by the IDT to include increased activities during	

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

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FORM APPROVED  
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F 353	<p>Continued From page 75 individual plans of care.</p> <p>The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:</p> <p>Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.</p> <p>Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interviews, and concerns expressed during the resident group meeting, it was determined the facility failed to have adequate staffing to meet the assessed needs of the residents. This was true for 7 of 15 (#s 1, 3, 4, 6, 8, &amp;12) sampled residents and had the potential to affect all residents. Findings include:</p> <p>A resident group interview was conducted on 2/1/11 at 10:30 a.m. Fifteen residents were in attendance. When asked "Are there enough staff here to take care of everyone?" multiple residents answered "no." When asked for mores specifics, the residents stated staffing was especially low on night shift and weekends. One resident stated they had to wait 45 minutes for assistance to the toilet one night. Several other residents agreed</p>	F 353	<p>waking hours and is in room close to nurse's station. Resident #3 received a shower by the CNA when identified during the survey. Resident #6's indwelling catheter was discontinued by the licensed nurse on 2/21/11. Resident #8 received a shower by the CNA when identified during the survey. Resident #4 was discharged from facility 2/17/11. Resident #12 was discharged from the facility on 2/13/11. Administrator reviewed staffing with the Staff Development Coordinator and Director of Nursing on 2-26-11 to ensure the needs are addressed.</p> <p><b>Identifying other residents having the potential to be affected, and what corrective action will be taken:</b> Resident council meeting was held with Regional Vice President on 2-28-11 to address any potential staffing concerns. <b>Measures and systemic changes to prevent recurrence:</b> Nursing staff were re educated by the Regional Director of Clinical Operations on or before 2/26/11 regarding providing bathing schedules, pressure ulcer</p>	

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

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F 353	<p>Continued From page 76</p> <p>that the wait for help on nights/weekends was long. One resident explained the staff never stop running, but there were not enough of them to go around. Yet another resident stated they are sometimes told by staff that they are "the only one on."</p> <p>A three week staffing schedule was reviewed for the weeks of 1/9/11, 1/16/11 and 1/23/11. The average number of residents in the facility for the time period was 65.4, with the lowest number being 63 on one date. The number of nursing staff hours worked per resident per day were calculated to be:</p> <ul style="list-style-type: none"> <li>* 1/9/11 Sunday - 2.6</li> <li>* 1/15/11 Saturday - 2.6</li> <li>* 1/16/11 Sunday - 2.4</li> <li>* 1/22/11 Saturday - 2.4</li> <li>* 1/23/11 Sunday - 2.7</li> </ul> <p>Staffing ratio concerns were discussed with the DON and RN clinical consultant during interview on 2/3/11 at 10:10 a.m. No further information was provided.</p> <p>Refer to F312 as it related to frequency of bathing for Resident #3, #8 and #12.</p> <p>Refer to F314 as it related to Pressure Ulcer prevention and treatment for Resident # 3 and #4.</p> <p>Refer to F315 as related to the prolonged use of an indwelling urinary catheter for Resident #6.</p>	F 353	<p>prevention and treatment, interventions for fall prevention and diagnosis for indwelling catheters.</p> <p>A review of shower schedules and documentation was completed to ensure residents receive showers accordingly. Residents identified as at-risk for skin breakdown were reviewed to ensure appropriate interventions are implemented and documented on the care plan. Residents with catheters will be reviewed initially during C.A.R.E. meeting and then quarterly for appropriateness. Resident's determined to be at high risk for falls upon admission will have interventions put into place at time of admit to include a plan for supervision which will be reviewed and discussed in clinical meeting with the interdisciplinary team.</p> <p><b>Monitoring Corrective Action for sustained corrections:</b> The Administrator or designee reviews daily staffing to ensure adequate levels to provide services according to resident care plans. POC &amp; audits will be reviewed by the facility Performance Improvement Committee monthly for</p>	

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135107</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/04/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>IDAHO FALLS CARE &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3111 CHANNING WAY IDAHO FALLS, ID 83404</b>	
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F 353	Continued From page 77	F 353	compliance & trends and make recommendations as needed for 3 months or until resolved.	
F 388 SS=D	<p>Refer to F323 as it related to lack of supervision to prevent falls for Resident #1 and Resident #6.</p> <p>483.40(c)(3)-(4) PERSONAL VISITS BY PHYSICIAN, ALTERNATE PA/NP</p> <p>Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally.</p> <p>At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and resident and staff interview, it was determined that the facility failed to ensure that the residents' physician made the initial visit to the residents when they were admitted to the facility. This was true for 3 of 13 (#s 5, 11 and 14) sampled residents. Findings include:</p> <p>1. Resident #5 was admitted to the facility on 8/6/09, and readmitted on 9/27/10, with diagnoses of Parkinson's, insulin dependent diabetes mellitus and dysphasia.</p> <p>The resident's initial history and physical was done 9/29/10, by the physician assistant. The "Physicians Progress Notes" documented that the physician assistant was at the facility to see the resident on 9/29/10 and 9/30/10. There was an</p>	F 388	<p><b>Completion Date: 3/2/2011</b></p> <p><b>F 388</b> <b>Corrective actions for residents affected:</b> Resident's #5, #11, and #14 have been examined by their physician on 2-24-11 and updated documentation is in the record.</p> <p><b>Identifying other residents having the potential to be affected, and what corrective action will be taken:</b> An audit was completed by the Health Information Manager on 2-23-11 to verify that the resident's physicians have visited according to regulations.</p> <p><b>Measures and systemic changes to prevent recurrence:</b> Return receipt request letters were mailed on 2/23/11 to the</p>	

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F 388	<p>Continued From page 78</p> <p>undated and unreadable written note to the right of the physician assistants' entry on the "Physicians Progress Notes" page.</p> <p>Resident #5 was interviewed 2/1/11 at 1:30 p.m. and did not remember when the physician came to visit her.</p> <p>The DON was interviewed on 2/1/11 at 2:45 p.m. and was not able to decipher the documentation that the physician wrote or when it was completed.</p> <p>2. Resident #11 was admitted to the facility on 10/6/10 with diagnoses of subdural hemorrhage following injury, muscle weakness, abnormality of gait and dysphagia.</p> <p>The residents' initial history and physical [H &amp; P] was completed on 10/8/10 by the physician assistant. The physician documented on the H &amp; P "...agree with above" and signed. The documentation was not dated. Review of the "Physician Progress Notes," revealed the only entry that the physician had made was on 12/22/10, most of which was not able to be deciphered. The physician assistant had made 13 visits to the resident prior to the physicians visit on 12/22/10.</p> <p>The Administrator and DON were informed of the findings on 2/3/11 at 3:30 p.m. No further information was provided.</p> <p>3. Resident #14 was admitted to the facility on 1/20/11 with diagnoses of congestive heart failure, chronic dizziness, urinary tract infection, left heel decubitus ulcer and hypertension.</p>	F 388	<p>attending physicians regarding the requirements for visits and use of physician extenders.</p> <p><b>Monitoring Corrective Action for sustained corrections:</b> The Health Information Manager will audit physician visits monthly for three months to ensure compliance. POC &amp; audits will be reviewed by the facility Performance Improvement Committee monthly for compliance &amp; trends and make recommendations as needed for 3 months or until resolved.</p> <p><b>Completion Date: 3/2/2011</b></p>	

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F 388	Continued From page 79 A 1/26/11 physician note documented, "This is an admit H&P." The report was signed by the Physician Assistant [PA]. The Physician Progress Notes page documented visits on 1/26/11, 1/31/11 and 2/1/11, all signed by the PA. The signature below the 1/26/11 entry varied from those of the other 2 dates. It was confirmed by LN #4 that the signature was that of the PA.	F 388		
F 441 SS=D	The Administrator and DON were informed of the findings on 2/3/11 at 3:30 p.m. No further information was provided. 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.  (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if	F 441	<b>F441</b> <b>Corrective actions for residents affected:</b> Resident #4 discharged from facility on 2/17/11.  <b>Identifying other residents having the potential to be affected, and what corrective action will be taken:</b> Infection control nurse completed review of infection control program to identify trends on 2-28-11. No trends were identified.  <b>Measures and systemic changes to prevent recurrence:</b> Nursing staff have been re-educated on hand-washing policy and procedure by the Regional Director of Clinical Operations on or before 2/26/11.	

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F 441	<p>Continued From page 80</p> <p>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 observation and interview, it was determined that the facility failed to ensure that hand hygiene was performed by staff providing personal care to a resident. This was true for 1 of 13 (#4) sampled residents. Findings include:</p> <p>Resident #4 was admitted to the facility 6/26/06, and readmitted on 4/17/09, with diagnoses of Alzheimer's disease, deficiencies of limbs and contracture of hand joint.</p> <p>The most recent quarterly MDS assessment, dated 12/2/10, documented that the resident:</p> <ul style="list-style-type: none"> <li>* had short and long term memory problems,</li> <li>* decision making skills were severely impaired,</li> <li>* required total assistance of one staff for transfers, dressing, eating, personal hygiene and bathing,</li> <li>* was incontinent of bowel and bladder,</li> <li>* was at risk for pressure sores but did not have one.</li> </ul> <p>On 2/1/11 at 8:55 a.m., CNA#1 and CNA#2 were observed providing incontinence care to Resident</p>	F 441	<p><b>Monitoring Corrective Action for sustained corrections:</b> DNS or designee will complete three observations/audits weekly for three months to ensure compliance with hand-washing. POC &amp; audits will be reviewed by the facility Performance Improvement committee monthly for compliance &amp; trends and make recommendations as needed for 3 months or until resolved.</p> <p><b>Completion Date: 3/2/2011</b></p>	

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F 441	Continued From page 81 #4.  CNA#1 washed her hands and put exam gloves on prior to the procedure. CNA#2 put gloves on without hand hygiene and proceeded to assist CNA#1. Both CNAs transferred the resident to bed. They proceeded to remove the resident's attends. CNA#2 applied barrier cream to the resident's buttock area then removed the exam gloves. CNA#1 removed her exam gloves and proceeded to put on a new pair of gloves without hand hygiene. Then CNA#1 did peri-care on the resident with moist wipes. CNA#1 removed her gloves after providing peri-care and the two CNAs finished fastening the attends and positioned the resident for comfort. Both CNAs washed their hands prior to leaving the room.  The administrator and DON were informed on 2/3/11 at 3:30 p.m. No further information was provided.	F 441		
F 514 SS=E	483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIBLE  The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.  The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.	F 514	<b>F514</b> <b>Corrective actions for residents affected:</b> Residents #5 & #11 have been examined by their physician on 2-24-11 and the physician's notes have been dictated. Resident #6-Catheter was discontinued on 2-21-11 and a Bowel & Bladder Evaluation started on 2-21-11 and completed on 2-25-11. Residents #1, #5 & #11-	

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F 514	<p>Continued From page 82</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, it was determined the facility failed to ensure medical records were complete and accurately reflected residents' stay at the facility. This was true for 4 of 15 (#s 1, 5, 6 and 11) sampled residents reviewed. Findings include:</p> <p>1. Resident #5 was admitted to the facility on 8/6/09, and readmitted on 9/27/10, with diagnoses of Parkinson's, insulin dependent diabetes mellitus and dysphasia.</p> <p>The physician made two visits to the resident and wrote progress notes. Neither of the notes are legible. The first note was not dated when it was written. The second note was dated 12/22/10.</p> <p>The DON was asked to interpret the notes on 2/1/11 at 2:45 p.m. and was not able to do so.</p> <p>2. Resident #11 was admitted to the facility on 10/6/10 with diagnoses of subdural hemorrhage following injury, muscle weakness, abnormality of gait and dysphagia.</p> <p>The physician assistant did a history and physical on 10/8/10. The physician reviewed the document and made a written note on it. The date that the note was made was not documented and the note was not legible enough to be reviewed.</p> <p>The physician visited the resident on 12/22/10 and made hand written documentation of the visit. The note was not legible enough that it could be reviewed for content.</p> <p>The administrator and DON were informed about</p>	F 514	<p>Physician &amp; Physician Assistant were re-educated on or before 2/28/11 by the Administrator and Director of Nursing on ensuring that the Medical records are complete and accurate.</p> <p><b>Identifying other residents having the potential to be affected, and what corrective action will be taken:</b> A review of Physician progress notes &amp; Bowel &amp; Bladder evaluations have been completed by the Director of Nursing or designee on 2-26-11 to ensure accurate, legible and dating of entries.</p> <p><b>Measures and systemic changes to prevent recurrence:</b> Return receipt letters were mailed on 2/23/11 to the attending physicians regarding the legibility and dating of physician progress notes. Licensed Nurses have been re-educated on accuracy, legibility and dating entries in the medical record by the Regional Director of Clinical Operations on or before 2/26/11 also to include completion of bowel and bladder evaluations.</p> <p><b>Monitoring Corrective Action for sustained corrections:</b></p>	

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F 514	<p>Continued From page 83</p> <p>the notes on 2/3/11 at 3:30 p.m. No further information was provided.</p> <p>3. Resident #6 was admitted to the facility on 5/15/09, and readmitted on 9/27/10, with diagnoses of polymyalgia rheumatica, diabetes mellitus type II, traumatic fracture of hip and personal history of fall.</p> <p>The resident record included 3 Bowel and Bladder Continence Evaluations. The most recent assessment was dated 10/9/10 - 10/15/10, and was not checked to indicate what type of assessment it was, i.e.. bowel, bladder or both bowel and bladder. The evaluation form stated "cath" (catheter), which was still in place at the time. "Scheduled voiding" was checked for the type of program in place, which would not be possible to initiate, as the resident had the indwelling catheter in place.</p> <p>The administrator and DON were informed about the notes on 2/3/11 at 3:30 p.m. No further information was provided.</p> <p>4. Resident #1 was admitted to the facility on 9/23/10 with diagnoses of traumatic fracture of lower leg, personal history of fall, and dementia.</p> <p>Review of Physician Assistant progress notes revealed the following:</p> <ul style="list-style-type: none"> <li>* 9/29/10 "She is an 88 year old female..."</li> <li>* 10/14/10 "She is an 80 year old female..."</li> <li>* 11/12/10 "She is a 70 year old female..."</li> </ul> <p>According to the resident face sheet, her date of</p>	F 514	<p>The Health Information Manager will perform three weekly audits for three months of medical records for legibility and accuracy to ensure compliance. POC &amp; audits will be reviewed by the facility Performance Improvement committee monthly for compliance &amp; trends and make recommendations as needed for 3 months or until resolved.</p> <p><b>Completion Date: 3/2/2011</b></p>	

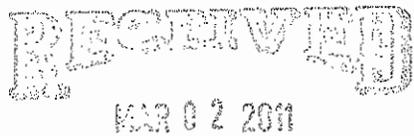
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F 514	Continued From page 84 birth was 11/27/39, which meant the resident was 70 years of age at the time of all 3 reports.	F 514			
F 518 SS=D	<b>483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS</b>  The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures.  This REQUIREMENT is not met as evidenced by: Based on staff interview and policy review, it was determined the facility failed to ensure 1 of 3 employees interviewed had sufficient knowledge to respond to emergencies and disasters (CNA A). This failure had the potential to place residents at an increased risk for adverse outcome, injury, or harm in the event of a fire, power outage, intruder or other emergency. Findings include:  On 2/1/11 at 3:45 p.m. CNA A was interviewed and asked questions related to emergency preparedness. The CNA stated she had worked in the facility for 2 months. When asked if she had knowledge/training on what to do in case of fire, power outage, armed intruder and other weather/natural disaster emergencies, she answered that she did not know and had not been trained. The CNA stated training was available on line that she had not completed.  Three other staff in the facility were interviewed and provided satisfactory answers to all questions.	F 518	<b>F518</b> <b>Corrective actions for residents affected:</b> No residents were identified. CNA A has received re-education on emergency preparedness on 2-23-11.  <b>Identifying other residents having the potential to be affected, and what corrective action will be taken:</b> Regional Director of Clinical of Operations, Maintenance Director, and/or Staff Development Coordinator presented education materials to the staff on or before 2-26-11 addressing emergency procedures. Training will be provided to newly hired staff upon hire and periodically thereafter.  <b>Measures and systemic changes to prevent recurrence:</b> Re-education to the staff was completed by the Regional Director of Clinical Operations, Maintenance Director &/or Staff Development Coordinator on or before 2/26/11. Training will be		

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F 518	Continued From page 85 The Administrator and consultants were informed of the staff training issue on 2/2/11 at 2:45 p.m. No further information was provided.	F 518	provided to newly hired staff upon hire and periodically thereafter.  <b>Monitoring Corrective Action for sustained corrections:</b> The Administrator or designee will complete a monthly audit for three months of newly hired staff to verify completion of emergency procedures training to ensure compliance. Audit trends will be reviewed by the facility Performance Improvement committee monthly for 3 months or until resolved.  <b>Completion Date: 3/2/2011</b>		

Bureau of Facility Standards

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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 state licensure survey of your facility.  The surveyors conducting the survey were:  Lea Stoltz, QMRP, (Team Coordinator) Arnold Rosling, BSN, RN, QMRP Amy Beam, BSN, RN	C 000	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, <b>Idaho Falls Care &amp; Rehabilitation Center</b> 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 111	02.100,02,f  f. The administrator shall be responsible for providing sufficient and qualified staff to carry out all of the basic services offered by the facility, i.e., food services, housekeeping, maintenance, nursing, laundry, etc. This Rule is not met as evidenced by: Refer to F353 as it related to sufficient nursing staff.	C 111	<b>C111</b> Refer to F353   MAR 02 2011  <b>FACILITY STANDARDS</b>	
C 243	02.106,05 ORIENTATION, TRAINING & DRILLS  05. Orientation, Training and Drills. All employees shall be instructed in basic fire and life safety procedures. This Rule is not met as evidenced by: Refer to F518 as it related to staff training for emergency preparedness.	C 243	<b>C243</b> Refer to F518	
C 361	02.108,07 HOUSEKEEPING SERVICES AND	C 361	<b>C361</b> Refer to F252	

Bureau of Facility Standards

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

*Mark Gunnell*

TITLE  
*Administrator*

(X6) DATE

*3-1-11*

Bureau of Facility Standards

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  02/04/2011
NAME OF PROVIDER OR SUPPLIER  IDAHO FALLS CARE & REHABILITATION CEN		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 361	Continued From page 1  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: Refer to F252 as it related to the environment.	C 361		
C 644	02.150,01,a,i  a. Methods of maintaining sanitary conditions in the facility such as:  i. Handwashing techniques. This Rule is not met as evidenced by: Refer to F441 as it relates to staff handwashing.	C 644	<b>C644</b> Refer to F441	
C 710	02.152,03,b,iv  iv. Ensures that identification of needs, implementation of programs to meet the needs and appropriate record keeping is accomplished. This Rule is not met as evidenced by: Refer to F250 as it is related to social services documentation of ongoing assessment and intervention.	C 710	<b>C710</b> Refer to F250	
C 736	02.154,02,e  e. A physician's plan of care shall be provided to the facility upon admission of the patient/resident	C 736	<b>C736</b> Refer to F388	

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C 736	Continued From page 2 which reflects medication orders, treatments, diet orders, activity level approved, and any other directives to the facility for the care of the patient/resident. This Rule is not met as evidenced by: Refer to F 388 as it relates to the physicians initial visit and care of the residents.	C 736		
C 778	02.200,03,a PATIENT/RESIDENT CARE  03. Patient/Resident Care.  a. A patient/resident plan of care shall be developed in writing upon admission of the patient/resident, which shall be: This Rule is not met as evidenced by: Refer to F279 as it related to initial care plans.	C 778	<b>C778</b> Refer to F279	
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 for Care Plan deficiency.	C 782	<b>C782</b> Refer to F280	
C 785	02.200,03,b,i  i. Good grooming and cleanliness of body, skin, nails, hair, eyes, ears, and face, including the removal or shaving of hair in accordance with patient/resident wishes or as necessitated to prevent infection; This Rule is not met as evidenced by:	C 785	<b>C785</b> Refer to F312	

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NAME OF PROVIDER OR SUPPLIER  IDAHO FALLS CARE & REHABILITATION CEN'		STREET ADDRESS, CITY, STATE, ZIP CODE 3111 CHANNING WAY IDAHO FALLS, ID 83404		
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C 785	Continued From page 3 Refer to F 312 as it related to residents personal hygiene.	C 785		
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 F 314 as it relates to pressure sores.	C 789	<b>C789</b> Refer to 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	<b>C790</b> Refer to F323	
C 795	02.200,03,b,xi  xi. Bowel and bladder evacuation and bowel and bladder retraining programs as indicated; This Rule is not met as evidenced by: Refer to F315 as it related to indwelling catheters.	C 795	<b>C795</b> Refer to F315	
C 798	02.200,04,a MEDICATION ADMINISTRATION  04. Medication Administration. Medications shall be provided to patients/residents by licensed nursing staff in accordance with established written procedures which shall include	C 798	<b>C798</b> Refer to F281 and F333	

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NAME OF PROVIDER OR SUPPLIER  <b>IDAHO FALLS CARE &amp; REHABILITATION CEN'</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3111 CHANNING WAY IDAHO FALLS, ID 83404</b>		
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C 798	Continued From page 4  at least the following:  a. Administered in accordance with physician's dentist's or nurse practitioner's written orders; This Rule is not met as evidenced by: Refer to F281 and F333 as they are related to medication administration.	C 798		
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 F 514 as it relates to legibility of medical records.	C 881	<b>C881 Refer to F514</b>	