



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: 7007 3020 0001 4044 6826

February 26, 2013

Dallas M. Clinger, Administrator
Power County Nursing Home
510 Roosevelt Street, PO Box 420
American Falls, ID 83211

Provider #: 135066

Dear Mr. Clinger:

On **February 15, 2013**, a Recertification and State Licensure survey was conducted at Power County Nursing Home by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be an isolated deficiency that constitutes actual harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies, and a similar State Form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3.) **Please provide ONLY ONE completion date for each federal and state tag in column X5 Complete Date, to signify when you allege that each tag will be back in compliance.** WAIVER RENEWALS MAY BE REQUESTED ON THE PLAN OF CORRECTION.

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **March 11, 2013**. Failure to submit an acceptable PoC by **March 11, 2013**, may result in the imposition of civil monetary penalties by **March 31, 2013**.

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

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

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

Dallas M. Clinger, Administrator
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- The administrator must sign and date the first page of both the federal survey report, Form CMS-2567 and the state licensure survey report, State Form.

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 CMS Region X of the results of this survey. We are recommending that CMS impose the following remedy:

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

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **August 11, 2013**, if substantial compliance is not achieved by that time.

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

If you believe these deficiencies have been corrected, you may contact Loretta Todd, R.N. or Lorene Kayser, L.S.W., Q.M.R.P., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0036, Phone #: (208) 334-6626, Fax #: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

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

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

- BFS Letters (06/30/11)

Dallas M. Clinger, Administrator
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2001-10 Long Term Care Informal Dispute Resolution Process
2001-10 IDR Request Form

This request must be received by **March 11, 2013**. If your request for informal dispute resolution is received after **March 11, 2013**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact us at (208) 334-6626.

Sincerely,

A handwritten signature in black ink that reads "Lorene Kayser". The signature is written in a cursive, slightly slanted style.

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

LKK/dmj
Enclosures

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

PRINTED: 02/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135066	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/15/2013
NAME OF PROVIDER OR SUPPLIER POWER COUNTY NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 510 ROOSEVELT STREET AMERICAN FALLS, ID 83211	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following deficiencies were cited during the annual licensure survey of your facility. The surveyors conducting the survey were: Sherri Case, BSW, LSW, QMRP, Team Leader Trish O'Hara, RN Survey Definitions: ADL = Activities of Daily Living CNA = Certified Nursing Assistant DON = Director of Nursing LN = Licensed Nurse MAR = Medication Administration Record RN = Registered Nurse	F 000	F 204 483.12(a)(7) PREPARATION FOR SAFE/ ORDERLY TRANSFER/DISCHRG	11Mar13
F 204 SS=D	483.12(a)(7) PREPARATION FOR SAFE/ORDERLY TRANSFER/DISCHRG A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to account for a discharged resident's belongings. This created the potential for personal belongings to be lost, misplaced or otherwise unaccounted for. This affected 1 of 1 (#8) closed records reviewed. Findings included: Resident #4 was admitted to the facility on 4/16/09 and passed away at the facility on 12/28/12. Review of the closed record did not provide	F 204	What corrective actions will be accomplished for those residents found to be affected by the deficient practice? Resident #8 was admitted 4/16/2009 and passed away at the facility on 12/28/2012. The personal belongings form was not signed by the family at the time of death. The resident's daughter is on dialysis and did not come in at the time of death. She did come in at a later date and the belongings form was given to her to review and sign, but was not verified for signature by PCSNF staff. The Resident Services Coordinator contacted the daughter to send her the form to verify, sign, and send back to the facility to ensure all resident items were received. The daughter came in and signed the form on 3/7/2013 and it has been added to the resident's chart. How will you identify other resident(s) having the potential to be affected by the same deficient practice and what corrective action(s) will be taken? This practice can affect all residents that are admitted to the facility, transfers, discharges or deaths. All residents are required to have a personal belongings	

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

TITLE

(X6) DATE

[Signature] CEO / ADMINISTRATOR 8 MAR 2013

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 204	Continued From page 1 evidence of an account of the resident's belongings. The record contained a form titled Inventory of Personal Effects (IPE). The IPE documented personal articles of an Amazon Kindle, 2 wheeled walker, a blanket and clothing. The IPE was signed when the resident was admitted by a CNA. The IPE was not signed by the facility when the resident was discharged. On 2/14/13 at 3:45 p.m., the surveyor informed the DON the resident's belongings were not accounted for. The DON stated the personal items were returned to the family and the IPE should have been signed by the family member.	F 204	form completed and signed by the family at the time of admission. A signature on the personal belongings form will also be required upon resident transfer, discharge or death in order to remove items from the resident room. The nursing staff will obtain the required signatures. What measures will be put in place or what systemic change will you make to ensure that the deficient practice does not recur? Any new admissions, transfers, discharges, or deaths will have the personal belongings form left with the nurses shift report to ensure it is completed in a timely manner and nursing staff are available to obtain a required signature from family during various times. On 3/7/2013, an information in-service sheet was also disseminated to the staff concerning the personal belongings form and the importance of completing it on admission, discharge, transfer or death and the importance of obtaining a family signature.		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).	F 225	How the corrective action(s) will be monitored to ensure the deficient practice will not recur? A QA audit to check all resident personal belonging forms for completeness will be done by the DON or ADON. These audits will begin		

3/11/2013 and will be done once (1) a week for four (4) weeks, two (2) times a month for two (2) months, one (1) time a month for six (6) months. Deficiencies in this practice will be reported to the QA committee for review to determine if further actions are needed. All monitoring will be documented and retained.

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F 225	Continued From page 2 The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview, review of the facility's abuse policy and record review, it was determined the facility failed to ensure that injuries of unknown origin were thoroughly investigated to rule out resident abuse or neglect. This was found for 2 of 5 (#2 and #3 6) sampled residents. Not thoroughly investigating injuries of unknown created the potential for residents to be abused or neglected. Findings include: The facility's Abuse Investigation Protocol included in section #3 that staff members who had contact with the resident during the 48 period prior to the time of the incident were to be interviewed. Additionally the policy stated the resident was to be interviewed as medically appropriate. 1. Resident #2 was admitted to the facility on 3/3/08 with diagnoses that included dementia,	F 225	F 225 483.13(c)(1)(ii-iii),(c)(2)-(4) INVESTIGATE/REPORT ALLEGATIONS What corrective actions will be accomplished for those residents found to be affected by the deficient practice? Resident #2 was seen by the podiatrist on January 10, 2013. He ordered Neosporin ointment and a Band-Aid to cover the ulcer on the tip of right 2 nd toe. A thorough investigation was not completed for those staff members that were on the 48-hours previous to the toe issue. The DON accompanied the resident on March 7, 2013 to the podiatrist for a follow-up appointment on the right 2 nd toe. It was debrided and healing well and the resident was given antibiotics and is to continue with follow-up appointments for treatment of the toe. The staff will monitor the placement of resident #2's feet on the pedals of her wheelchair to prevent dragging of the feet and unnecessary strain. Additional foam padding was also added to the pedals of her wheelchair to prevent her from dragging her feet. All unknown injuries will be investigated more thoroughly with documented interviews of all staff on shift in the	11Mar13	

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F 225	<p>Continued From page 3 agitation, psychosis and macular degeneration.</p> <p>Although the resident's MDS quarterly dated 11/20/12 documented she was severely cognitively impaired, the nurse interviewed after the initial tour identified the resident was able to answer simple questions.</p> <p>*Resident #2's medical record included a 1/10/13 order from a podiatrist to "Please apply Neosporin oint[ment] and Band-Aid to ulcer on tip of right 2nd toe...."</p> <p>Nursing notes (NN) reviewed from 12/28/12 through 1/10/13 documented nothing about the resident's right 2nd toe. A nursing note dated 1/10/13 at 10:00 a.m. documented the above order.</p> <p>On 2/13/13 at 10:30 a.m. the surveyor observed the wound on the resident's right 2nd toe. The wound was an unopened area 0.5 cm x 0.25 cm. The outer area of the wound was red.</p> <p>Alteration In Skin Reports (AISR) for 12/1/12 through 12/28/12 documented, "none" in the problem section of the skin assessment. The AISRs for the week of 12/29/12 through 1/10/13 were not provided.</p> <p>On 2/14/13 at 10:45 a.m., the DON was asked for any additional information regarding the above ulcer. The DON stated there should have been a Quality Measure (QM) report (incident/accident report) for the ulcer. The DON did not respond when asked how injuries could be prevented if a QM or investigation had not been completed to identify the source of the injury.</p>	F 225	<p>previous 48-hours by the nursing staff and DON or ADON.</p> <p>Resident #7 received a bruise to her right posterior forearm on January 17, 2013. The documentation states that she got the bruise between bathroom trips during the night. Upon inspection by the DON, there are no sharp objects in the bathroom doorway or around the toilet to cause this. She uses a walker and may have bumped her arm on the doorway or wall. All unknown injuries will be investigated more thoroughly with documented interviews of all staff on shift in the previous 48-hours by the nursing staff and DON or ADON.</p> <p>How will you identify other resident(s) having the potential to be affected by the same deficient practice and what corrective action(s) will be taken?</p> <p>QMM forms are to be completed on all residents with bruises, falls, skin tears, medication errors and other type of injuries known and unknown for reporting. This has the potential to pertain to all the residents.</p> <p>On March 7, 2013, the staff was given inservice on investigating and reporting more details of source and nature of injuries and more thoroughly completing the facility QMM forms. The nursing staff and DON or ADON will do more comprehensive interviews with the</p>		

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F 225	<p>Continued From page 4</p> <p>*A Skin tear/bruise-report/investigation, (IR) dated 4/11/12 documented 2 sores that were scabbed to the resident's left ankle that were 1 cm x 0.5 cm and 1 cm x 0.25 cm. The IR documented the probable cause of the scabbed sore was pressure.</p> <p>The IR identified 1 staff as on duty. In the What Does Staff Say Occurred section, staff stated, "It looks like pressure sores." There was no indication of the cause of the pressure (such as shoes, legs together etc.).</p> <p>The investigation did not include any information regarding the resident being interviewed, such as refused or unable.</p> <p>On 2/14/13 at 10:45 a.m. the DON was asked for any more information regarding the above ulcers. The DON did not respond when asked how injuries could be prevented if a QM or investigation did not identify the source of the injury.</p> <p>*An IR dated 3/8/12 documented Resident #2 had a bruise on her right first finger. The IR documented the person completing the IR and 3 other staff were working when the bruised finger was observed. The comments section stated, "Rt [resident] may have caught finger in w/c [wheelchair]." The IR did not include any written statements from staff on duty when the injury was observed. The investigation did not include any information that the facility attempted to interview the resident. In the Conclusion section, "I do not believe abuse has occurred" was marked. The Unable to Determine Cause, Probable Cause for</p>	F 225	<p>resident and all staff on shift in the previous 48-hours for all injuries of an unknown source and document those responses on the QMM. All QMMs will continue to be sent through the review process for review, recommendations, and signatures by the DON or ADON, QA Director, and the Administrator, prior to being tracked and filed for completeness by the MDS Coordinator.</p> <p>What measures will be put in place or what systemic change will you make to ensure that the deficient practice does not recur? QMM forms and an investigation are to be completed on all residents with bruises, falls, skin tears, medication errors and other types of injuries for reporting. The staff will receive inservices on documenting more details on the QMM form about the source, circumstances, and nature of any resident injuries found. These details will also need to be documented on an additional form (see attached) to be attached to the QMM as part of the investigation. The nursing staff and DON or ADON will conduct a more comprehensive investigation of all unknown injuries reported by documenting and conducting additional interviews of the resident and all staff</p>		

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F 225	<p>Continued From page 5</p> <p>the Bruise and Preventative Measures sections of the IR were blank.</p> <p>*Resident #2's Nursing Notes (NN) documented on 2/2/13, "Right hand middle finger bruise is red and purple." NN on 2/3/13 documented the bruise on the finger was unchanged and on 2/4/13 the "bruise is resolving."</p> <p>On 2/14/13 at 10:45 a.m. the DON was informed of the two incidents of bruised fingers for Resident #2. The investigation report for the 2/2/13 incident was requested. No further information was provided.</p> <p>*Resident #2's NN documented on 3/25/12, "New bruise found on mid right shin."</p> <p>During the interview with the DON on 2/14/13 a copy of the investigation was requested. No further information was provided by the facility.</p> <p>2. Resident #7's medical record included an IR dated 1/7/13 documenting a bruise on the right posterior forearm.</p> <p>The IR documented the resident did not know how she got the bruise and that two staff were on duty when the bruise was observed. The Comment section of the IR documented, "Resident got a bruise in between bathroom trips last night." The investigation did not include written statements from the staff. The Administrative Review Preventative Measures section was left blank.</p> <p>On 2/14/13 at 5:00 p.m. the Administrator and the DON were informed of the lack of thorough</p>	F 225	<p>who have worked the previous 48 hours. A QMM form is to be completed by the nurse who will interview the resident, staff working at the time of the incident, and a check of all equipment that may be involved with the injury. An additional modified new form will also be attached to the QMM and requires that any staff that was present at the time of the injury and any staff working the previous 48-hours document their statement regarding the injury. The QMM and additional form will then be given to the DON or ADON for review that it is complete, any additional recommendations, and signature. The QMM is then given to the QA Coordinator for review and signature and then to the Administrator for review and signature. These forms will then be returned to the MDS Coordinator for review, input into the computer, and filed in a QA binder. No QMM will be filed without a complete investigation regarding unknown injuries.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur? A QA audit will be completed by the MDS Coordinator on all QMMs with injuries of unknown origin to ensure a complete investigation was done, including interviewing the resident if</p>		

able to respond, checking any equipment that may be involved, staff interviews with those that were present at the time of the incident and all staff scheduled 48-hours prior to the incident. The audit will also check for review and signatures of the DON, QA Director, and Administrator before being filed by the MDS Coordinator. These audits will begin 3/11/13 and they will be done three (3) times a week for six (6) weeks, then two (2) times a week for six (6) weeks, then one (1) time a week for four (4) weeks. Deficiencies in the practice will be reported to the QA committee for review to determine if further actions are needed. All monitoring will be documented and retained.

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F 225	Continued From page 6 investigations. No further information was provided by the facility.	F 225	F 241 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY What corrective actions will be accomplished for those residents found to be affected by the deficient practice? Residents #1, #3, and #5 were served their meals with disposable dishes. The residents that were at the table before meals were also served water in disposable cups. The Dietary staff was notified of the issue with using disposable items and all disposable cups were removed from the tables and replaced with glassware. The Dietary staff will use glassware for each meal, clean and return any needed cups back to the nursing home for use.	11Mar13
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to enhance residents' dignity during dining. This was true for at least 15 residents, including sample residents #s 1, 3 and 5 who were served their meals in disposable dishes. This failure created the potential for a negative effect on residents' psycho-social well being. Findings included: During the morning meal observation on 2/12/13 at 8:00 a.m. at least 7 residents who received water with their morning were served the water in a 4 oz disposable cup. Later during the evening meal observation at 6:05 pm no less than 8 residents received their coleslaw and dessert in small disposable bowls. On 2/14/13 at about 4:00 p.m. the Dietary Manager was informed that disposable dishware was not allowed. The DM stated she often used disposables dishware for meals as she was not aware that it was not to be used on a regular basis.	F 241		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES	F 314	How will you identify other resident(s) having the potential to be affected by the same deficient practice and what corrective action(s) will be taken? All residents in the facility have the potential to be affected by this practice. The Dietary staff will no longer serve desserts, salads, or sides in disposable dishware. The Dietary staff will no longer use disposable cups for resident meals.	

What measures will be put in place or what systemic change will you make to ensure that the deficient practice does not recur?

The Dietary staff will no longer serve desserts, salads, or sides in disposable dishware. The Dietary staff no longer uses disposable cups for resident meals.

How the corrective action(s) will be monitored to ensure the deficient practice will not recur?

A QA audit will be completed by the DON or ADON to ensure that no disposable dishes are used on the meal trays or for beverages while waiting for meals. These audits will begin 3/11/13 and they will be done three (3) times a week for four (4) weeks, then two (2) times a week for four (4) weeks, and then one (1) time a week for four (4) weeks. Deficiencies in this practice will be reported the District QA Committee for review to determine if further actions are necessary. All monitoring will be documented and retained.

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F 314	Continued From page 7 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 1 of 2 sample residents (#2) reviewed for pressure ulcer prevention did not develop an avoidable pressure ulcer. Resident #2 was harmed when 3 Stage II pressure ulcers developed while at the facility. Findings included: Resident #2 was admitted to the facility on 3/3/08 with diagnoses that included dementia, agitation, psychosis and macular degeneration. Resident #2's most recent quarterly MDS assessment, dated 11/20/12 documented she required extensive assistance of 2 staff for bed mobility, transfers, dressing and personal hygiene. The assessment stated the resident was at risk for pressure ulcers but did not have any at the time of the assessment. Resident #2's medical record included history of a pressure sore to her right great toe on 3/31/11. An Alteration In Skin Report (AISR) dated 10/2/11 documented the resident had a pressure sore	F 314	F 314 483.25(c) TREATMENT TO PREVENT/HEAL PRESSURE SORES What corrective actions will be accomplished for those residents found to be affected by the deficient practice? Resident # 2 had a pressure sore to her right great toe on 3/31/11 caused by her sock being rolled up in her shoe. The podiatrist had seen her for this and monitored it closely including debridement of the area several times. This sore pressure sore was resolved by November of 2011. Her shoes were replaced by slippers and she was monitored closely by staff to prevent it from recurring again. She is able to wheel herself around in the wheel chair using her arms and not her feet. Her feet are to be placed on the pedals of her wheel chair. Resident #2 also had two small scab areas on her left ankle on 4/11/12. Staff members were unaware of what happened. That particular area is very contracted and her feet will be monitored closely for placement when in bed or in the wheel chair. These scabs were resolved on 4/27/12 and 5/17/12 respectively. Resident #2 also developed an area on the tip of her right 2 nd toe.	11Mar13	

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F 314	<p>Continued From page 8</p> <p>caused from her sock rolling up in her shoe and the podiatrist had debrided "it again on 9/1/11."</p> <p>The Braden Scale for Predicting Pressure Sore Risk documented on 3/9/12, 8/4/12 and 11/9/12, that Resident #2 was at moderate risk for developing pressure ulcers.</p> <p>a. Resident #2's 4/11/12 NN, documented the left, "Ankle with 2 open/scabbed areas." The note documented the one was 1 cm x 0.5 cm and the other was 1 cm x 0.25 cm. The 4/12/12 NN documented, "Rt [resident] has 2 scabbed sores on outer L [left] ankle where foot is very contracted down and ankle has rubbed..."</p> <p>An Investigation dated 4/11/12, documented the resident had 2 sores on her left ankle as stated above. The What Does Staff Say Occurred section stated "looks like pressure sores." The Comments section under Administrative Review stated "Use pillows to elevate. Has boots to wear to relieve pressure." The investigation did not indicate what caused the pressure to the resident's ankles, therefore it was not clear how the pillows or boots would prevent future pressure ulcers. The care plan did not include the resident was to wear boots to prevent pressure ulcers. The resident was observed wearing slippers or socks, but not pressure relieving boots during observations on 2/12/13 through 2/14/13.</p> <p>The 4/12/12 AISR documented the 2 ulcers and stated in the Recommendations or Comments section, "L [left] foot is very contracted needs more padding." During observations on 2/12/13 through 2/14/13 staff was observed to put pillows behind her legs.</p>	F 314	<p>The podiatrist saw the resident on 1/10/13 and shaved a callous-like area on her toe and ordered Neosporin and a Band-Aid. The DON accompanied the resident to the podiatrist on 3/7/11 for a follow-up appointment for debridement and antibiotic. The area is healing well. Resident #2 will continue to see the podiatrist and staff will monitor this area for treatment. On 3/7/11 the staff also added additional foam padding to the pedals of resident #2's wheelchair to prevent the dragging of her feet and unnecessary strain. The DON or ADON will conduct a QA audit beginning 3/11/13 to be done three (3) times a week times six (6) weeks, two (2) times a week for six (6) weeks, then one (1) time a week for six (6) weeks. This will monitor placement of her toes, heels, ankles and any areas of her feet that may be in contact with her wheel chair that can cause pressure; and to ensure that her pedals are down and her feet are placed on the pedals without causing pressure. Deficiencies in this practice will be reported to the QA committee for review to determine if further action is needed.</p> <p>How will you identify other resident(s) having the potential to be affected by the same</p>		

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F 314	Continued From page 9 Wound or Pressure Care Identification and Progress Records documented the following: 4/12/12 - Two ulcers that were unstageable, without pain, no drainage and 100% Eschar (dead skin) on the left foot near the ankle bone. The sizes were documented as 1.5 cm x 1 cm and the other was 1 cm by 1 cm. 4/21/12 - The size of the pressure ulcers was the only change in the documentation which documented both ulcers were now 1 cm by 1 cm. 4/27/12 - One of the pressure ulcers was documented as resolved. The other was documented as a stage I that was 1/2 cm by 1/2 cm with no drainage, 100% epithelialization (regeneration of the top layer of skin). 5/5/12 - The remaining ulcer was documented as a Stage I with no drainage and 100% epithelialization. 5/17/12 - The ulcer was documented as resolved. b. Resident #2's medical record included a 1/10/13 order from a podiatrist to "Please apply Neosporin oint[ment] and Band-Aid to ulcer on tip of right 2nd toe...." Nursing notes (NN) reviewed from 12/28/12 through 1/10/13 documented nothing about the resident's right 2nd toe. A nursing note dated 1/10/13 at 10:00 a.m. documented the above order. On 2/12/13 at 9:26 a.m. Resident #2 was	F 314	deficient practice and what corrective action(s) will be taken? All residents in the facility have the potential to be affected by this practice. The staff nurses will be assigned residents for skin checks weekly and the skin nurses will continue to complete weekly skin assessments on all residents. This will allow the residents to have two (2) complete skin checks weekly and cover any skin issues. The skin assessments completed by each staff nurse will be turned in to the DON or MDS Coordinator on the day they are completed. What measures will be put in place or what systemic change will you make to ensure that the deficient practice does not recur? The additional assessments of assigning residents to the staff nurses as well as the skin nurses will require a full skin assessment with documentation two (2) times a week and should resolve the skin issues not being documented or addressed. The LPN and RN skin nurses will complete full skin assessments on all residents weekly to address new issues and any old issues. An inservice and training will be done for the nurses on doing the weekly skin assessments. The skin nurses will also receive additional training and inservice on skin assessments and care by attending a		

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F 314	<p>Continued From page 10</p> <p>observed in the activity/dining room with her foot off of the foot pedal of her wheelchair. Her foot was pointing down with her toes touching the floor and the back of her foot against the foot pedal.</p> <p>On 2/13/13 at 10:30 a.m. the surveyor observed the wound on the resident's right 2nd toe. The wound was an unopened area 0.5 cm x 0.25 cm. The outer area of the wound was red. LN #1 confirmed the area was red around the outer edges.</p> <p>The Director of Therapy was interviewed on 2/12/14 at 11:10 a.m. regarding the resident's foot not being on the foot pedal and the possibility of pressure on the heel and the toe. The therapist stated his concern regarding the resident's comfort as well as pressure and immediately adjusted the resident's wheelchair pedal.</p> <p>AISRs for 12/1/12 through 12/28/12 documented, "none" (no skin issues) in the Problem section of the Skin Assessment. The surveyor requested all weekly AISRs from 12/1/12 through 2/13/13; however, none were provided for 12/29/12 through 1/10/13.</p> <p>On 2/14/13 at 10:45 a.m., the DON was asked for any additional information regarding the above ulcer. The DON stated there should have been a Quality Measure (QM) report (incident/accident report) for the ulcer. The DON did not respond when asked how injuries could be prevented if a QM or investigation had not been completed to identify the source of the injury. The surveyor requested any information regarding the above ulcers. Later that day the DON provided additional AISRs; however, no QM, Wound</p>	F 314	<p>wound care conference in Eastern Idaho as conference becomes available.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur? A QA audit will be completed by the DON or MDS Coordinator to monitor any change in the skin condition of all residents. These audits will begin 3/11/13 and will be done three (3) times a week times four (4) weeks, two (2) times a week for six (6) weeks, then one (1) time a week for six (6) weeks. The DON and MDS Coordinator will also meet weekly for six (6) months with the two skin nurses to review all resident assessments and if there are any skin issues. Deficiencies in this practice will be reported to the QA committee for review to determine if further actions are needed. All monitoring will be documented and retained.</p>		

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F 314	<p>Continued From page 11</p> <p>Pressure Sore Identification form documenting wound size, drainage etc. or any other documentation for the cause of the ulcer was provided.</p> <p>Resident #2's "Narrative Care Plan" (CP), dated 2/12 included a goal to not have any skin breakdown during the next quarter. The only revision to the CP was to use a moisture barrier when needed, dated 3/5/12. The Area/Problem/Strength included: daily skin checks, repositioning, pressure relieving mattress, pressure relieving pad in wheel chair, float heels in recliner and bed ensuring there was nothing in the toe of her shoe as she previously had a pressure sore on her toe, placing a pillow between her knees when she was in bed to prevent knees and feet from rubbing and extra protein at each meal. The CP did not include any intervention changes after the pressure ulcers were identified on 4/12/12.</p> <p>On 2/14/13 at 10:45 a.m. the DON was asked for any additional information regarding the above ulcers. The DON did not respond when asked how injuries could be prevented if a QM or investigation did not identify the source of the injury. Later that day the DON provided the investigation for the 4/11/12 ulcers; however the investigation did not identify what caused the pressure ulcers.</p> <p>Resident #3 was harmed when the facility failed to prevent avoidable pressure ulcers by identifying the cause of the pressure and implementing preventative measures to specifically address the reason for the pressure ulcers.</p>	F 314			

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F 314	Continued From page 12	F 314	F 329 483.25(I)	11Mar13	
F 329 SS=D	<p>On 2/14/13 at 5:00 p.m. the Administrator and the DON were informed of the above concerns. The facility provided no further information.</p> <p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility did not ensure residents were free from unnecessary drugs as</p>	F 329	<p>DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>What corrective actions will be accomplished for those residents found to be affected by the deficient practice? Resident # 2 was given Alprazolam 0.25mg on 10/17/12 for increased anxiety following the death of her roommate. The medication was discontinued at the pharmacy review on 8/8/12. The old MARS are checked with the new MARS each month and changes made if needed. This medication was overlooked on the new MARS and was not discontinued as it should have been. All nurses were given an inservice on 3/7/13 instructing that if you make an attempt to give a PRN medication and there is not a PRN card in the locked med cart for that resident, then a recheck of the chart and the doctor's orders, recaps, and pharmacy review forms should be checked to confirm the PRN medication order. The order should be verified prior to getting a PRN medication from the hospital.</p> <p>How will you identify other resident(s) having the potential to be affected by the same deficient practice and what corrective action(s) will be taken?</p>		

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F 329	Continued From page 13 evidenced by a resident received an anxiolytic after the physician had discontinued the medication. This was true for 1 of 5 sample residents (Resident #2) reviewed for medication use. This created the potential for harm because unnecessary medications can lead to adverse reactions and health decline. Findings included: Resident #2 was admitted to the facility on 3/3/08 with diagnoses that included dementia, agitation, psychosis and macular degeneration. Resident #2's clinical record contained a Physician Action Report, dated 8/8/12, that documented Alprazolam (an antianxiety drug) was discontinued due to non-use. However, Resident #2's medication administration record, dated 10/17/12, documented Resident #2 received Alprazolam 0.25 mg by mouth "for [increased] anxiety [with] 'passing' of roommate." A document titled Explanation of Medication Error, dated 10/18/12, stated the reason for the error was the medication was never taken off Resident #2's medication administration record. When asked on 2/14/13 at 10:45 a.m. the DON stated the nurse had been instructed to in the future to check the chart to see if the medication had been discontinued prior to borrowing a medication from the hospital.	F 329	All residents receiving medications in the facility have the potential to be affected by this practice. If there is no PRN card in the med cart for a resident, the nurse will double check and verify a current PRN order in the resident chart, prior to getting and giving a PRN medication. What measures will be put in place or what systemic change will you make to ensure that the deficient practice does not recur? A 3-step process will be used to check the medications and MARS. First, the DON will review the old and new MARS medications at the end of each month. Second, the DON will check that the correct dose and the medications are filled for the new month. Third, the nurse working the last night of the month, will check that all medication in the MARS and the medications filled for each resident are correct before putting the medications in the med cart. A list of changes that need to be made on the MARS will be called and faxed to the pharmacy for changes to be done and reprinted on the MARS.		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a	F 441	How the corrective action(s) will be monitored to ensure the deficient practice will not recur? A QA audit will be completed by the DON or ADON to check each resident chart and MARS for medication changes		

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F 441	<p>Continued From page 14</p> <p>safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(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.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</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, staff interview, and review</p>	F 441	<p>or new orders. These audits will begin 3/11/13 and will be done two (2) times a week for two (2) weeks, then once (1) a week for eight (8) weeks. Deficiencies in this practice will be reported to the QA committee for review to determine if further actions are necessary. All monitoring will be documented and retained.</p> <p>F 441 483.65</p> <p>INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>What corrective actions will be accomplished for those residents found to be affected by the deficient practice? Resident #2 was assisted to the bathroom by aide #2 and she did not wash her hands on two (2) different occasions for more than the 20 seconds required for sufficient hand washing. An inservice covering proper hand washing was given to the staff on 3/7/13. A hand washing inservice will also be done by the Infection Control Officer in three available classes 3/19-21/13 for the aides and licensed staff. Infection Control Officer will cover the topics of hand washing, sharing of linens, and proper</p>	11Mar13	

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F 441	<p>Continued From page 15</p> <p>of staff inservice curriculum, it was determined the facility failed to ensure an active infection control program with process surveillance that effectively minimized resident exposure to potential sources of infection. This included ineffective hand washing, a sharing of linens, and not using a protective barrier for a glucometer. This directly impacted 3 of 7 sample residents (#2, 4 & 5) and had the potential to impact all residents at the facility. Findings include:</p> <p>1. Resident #2 was admitted to the facility on 3/3/08 with diagnoses that included dementia, agitation, psychosis and macular degeneration.</p> <p>Resident #2's most recent quarterly MDS assessment, dated 11/20/12 documented she required extensive assistance of 2 staff for bed mobility, transfers, dressing, toilet use and personal hygiene.</p> <p>During an observation on 2/12/13 at 4:25 CNA #2 was assisting Resident #2 to use the toilet. CNA #2 was observed with gloves on and had the resident stand, using the grab bars. CNA #2 used a pre-moistened cloth to provide peri-care to the resident. The CNA then removed her gloves and assisted the resident to the sink. The resident washed her hands and then CNA #2 washed her hands for no more than 10 seconds.</p> <p>2. Resident #4 was admitted to the facility on 6/22/09 with diagnoses that included diabetes, dementia with mood disorder and chronic kidney disease.</p> <p>Resident #4's most recent quarterly MDS assessment, dated 12/12/12, documented she</p>	F 441	<p>use of barriers and cleaning of equipment in the resident rooms.</p> <p>Resident #4's blood sugar was checked by nurse #3. She did not put a barrier down before placing the blood sugar monitor on resident #4's bedside table. She again brought the monitor to the cart that held the medical records and put it down without a barrier. She completed the procedure correctly, except for using a barrier. The staff will be inserviced by the Infection Control Officer on using a barrier with the glucose monitors or other medical equipment in patient rooms.</p> <p>Lap blankets are kept in the living room area for the residents to be covered for comfort while they are resting or watching TV. One blanket was used to cover resident #2 and during an observation in the afternoon the same blanket was used on resident #5. The blankets will not be used on different residents and will be washed at the end of each shift to prevent sharing by another resident.</p> <p>How will you identify other resident(s) having the potential to be affected by the same deficient practice and what corrective action(s) will be taken?</p> <p>All residents in the facility have the potential to be affected by this practice. The staff will be in-serviced on best</p>

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

PRINTED: 02/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135066	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/15/2013
NAME OF PROVIDER OR SUPPLIER POWER COUNTY NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 510 ROOSEVELT STREET AMERICAN FALLS, ID 83211		
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F 441	<p>Continued From page 16</p> <p>required extensive assistance for mobility, transfer, dressing and toilet use.</p> <p>*During an observation on 2/12/13 at 4:25 CNA #2 was assisting Resident #4 to use the toilet. CNA #2, who had gloves on, assisted the resident to stand using the grab bars. CNA #2 then provided peri-care for the resident. After pulling the resident's pants up, the CNA removed her gloves and assisted the resident to the sink. The resident washed her hands and CNA #2 washed her hands for no more than 6 seconds.</p> <p>After the observation CNA was asked how long she had washed her hands and stated she did not know. The CNA was then asked how long she was suppose to wash her hands and she stated, "for 30 seconds."</p> <p>*On 2/13/13 at approximately 5:00 p.m. LN #3 was observed going into Resident #4's room, carrying a blood glucose monitor. Resident #4 gave permission for the surveyor to observe LN #3 check her (Resident #4's) blood sugar level. LN #3 was observed to place the blood glucose monitor on Resident #4's bedside table, wash her hands and put gloves on. LN #3 checked the Resident's blood sugar, placed the meter on the resident's bed, removed her gloves and washed her hands. LN #3 then picked up the meter, returned to the nurses station and placed the meter on the cart that held medical records for the residents. LN #3 than used a bleach solution to clean the blood glucose meter.</p> <p>On 2/14/13 the Administrator and the DON were informed a barrier had not been placed under the blood glucose meter prior to putting it on the bed</p>	F 441	<p>practice infection control for hand washing, sharing of linens, and proper use of barriers with medical equipment in the resident rooms.</p> <p>What measures will be put in place or what systemic change will you make to ensure that the deficient practice does not recur? The Infection Control Officer will provide the staff with inservice instruction on infection control best practices including proper hand washing, not sharing linens, proper use of equipment and using a barrier. These inservices will be given on 3/19/13 for the aides, 3/20/13 for the nurses, and 3/21/13 for the aides. Inservice sheets were also put out 3/7/13 for all staff to review on hand washing, using a barrier with blood sugar monitors, and not sharing linens with the residents. Each resident uses one lap blanket for the day. Lap blankets will be taken to dirty laundry when residents are taken from the lounge for meals or activities. This eliminates accidental use of soiled blankets by another resident or staff member.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur? A QA audit will be completed by the DON or ADON and Infection Control Officer to monitor proper hand washing.</p>	<p><i>Don Pen & Ink Change each time they sit in a resident I care 3/22/13 1:55p</i></p>	

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F 441	<p>Continued From page 17</p> <p>side table. No further information was provided by the facility.</p> <p>3. During an observation on 2/12/13 at 10:00 AM, Resident #2 was noted to be in a reclining chair in the living room. She was covered from neck to toe with a dark red paisley blanket. During an observation on 2/12/13 at 5:00 PM, Resident #5 was noted to be in the same chair in the living room covered from shoulder to toe with the same blanket.</p> <p>In an interview on 2/14/13 at 10:30 AM, the DON stated each blanket was dedicated to a specific resident and residents should not have been using the same blanket.</p> <p>In an interview on 2/15/13 at 9:30 AM the facility's Infection Control Officer explained the Infection Control Program. She said each staff member is required to complete an annual inservice that includes training on Bloodborne Pathogens and handwashing. She said staff were trained to clean their hands with soap and water for 20 - 30 seconds, or with alcohol based hand sanitizer for 15 seconds and 10 handwashing audits were done each month by herself or the DON. She further stated that blankets should not be shared by residents, but no program surveillance was done to ensure that it did not happen. When asked, she said it would be appropriate to use the glucometer in a resident's room without a protective barrier as long as it was cleaned appropriately before and after use.</p>	F 441	<p>These audits will begin 3/11/13 and will be done three (3) times a week for six (6) weeks, two (2) times a week for four weeks, and one (1) time a week for four (4) weeks. A QA audit will be completed by the DON or ADON on using a barrier with the blood sugar monitor and proper cleaning of it. These audits will begin 3/11/13 and will be done three (3) times a week for six (6) weeks, two (2) times a week for four (4) weeks, and one (1) time a week for four (4) weeks. A QA audit will be completed by the DON or ADON on not using the same lap blanket on different residents and the washing of the linens at the end of shifts. These audits will begin 3/11/13 and will be done three (3) times a week for six (6) weeks, two (2) times a week for four (4) weeks, and one (1) time a week for four (4) weeks.</p> <p>Deficiencies in any of these practice(s) will be reported to the QA committee for review to determine if further action(s) are needed. All monitoring will be documented and retained.</p>		

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 licensure survey of your facility. The surveyors conducting the survey were: Sherri Case, BSW, LSW, QMRP, Team Leader Trish O'Hara, RN	C 000		
C 175	02.100,12,f f. Immediate investigation of the cause of the incident or accident shall be instituted by the facility administrator and any corrective measures indicated shall be adopted. This Rule is not met as evidenced by: Please refer to F225 as it related to not thoroughly investigating unknown injuries.	C 175	C175 02.100,12,f	11MAR13
C 412	02.120,05,l l. A drinking fountain connected to cold running water and which is accessible to both wheelchair and nonwheelchair patients/residents shall be located in each nursing or staff unit. This Rule is not met as evidenced by: Based on observation and staff interview, it was determined the facility did not have a drinking fountain located on the ground floor nursing or staff unit that was connected to cold running water and that could be accessed by both residents who used wheelchairs and those who did not. Findings include:	C 412	C412 02.120,05,l	11MAR13

Bureau of Facility Standards

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

STATE FORM

TITLE

CEO / ADMINISTRATOR

(X6) DATE

8 MAR 2013

Bureau of Facility Standards

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C 412	Continued From page 1	C 412		
	During the survey process, it was noted that there was no water fountain available for residents on the ground floor of the facility.			
	On 2/15/13 at 9:00 AM, the Director of Nursing stated that the Administrator intended to request a waiver of this requirement.			
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 related to standard precautions for infection control.	C 644	C644 02.150,01,a,i Please refer to the corrective action for federal citation F441 on page 15 of 18, of the form CMS-2567 as it relates to handwashing techniques and standard precautions for infection control.	11MAR13
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: Please refer to F314.	C 789	C789 02.200,03,b,v Please refer to the corrective action for federal citation F314 on page 8 of 18, of the form CMS-2567 as it relates to prevention and treatment of decubitus ulcers.	11MAR13
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	C798 02.200,04,a Please refer to the corrective action for federal citation F329 on page 13 of 18, of the form CMS-2567 as it relates to a resident receiving a medication without a current order.	11MAR13

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C 798	Continued From page 2 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: Please refer to F329 as it relates to a resident receiving a medication without a current order.	C 798	C882 02.203,02,a What corrective actions will be accomplished for those residents found to be affected by the deficient practice. Resident #8 was admitted to the facility on 4/16/09. The resident died in the facility on 12/28/12. The closed record was reviewed. However a final diagnosis or cause of death was not included. The Administrator has spoken with the area coroner and doctors and asked that they send a copy of the death certificate for resident #8. The certificate has the doctor's signature and cause of death listed. This will be filed with the resident's chart for storage. How will you identify other resident(s) having the potential to be affected by the same deficient practice and what corrective action(s) will be taken. All residents in the facility have the potential to be affected by this practice. In the event of any future resident death or discharge, the Medical Records Director will contact the doctor to document a final diagnosis in the chart for discharge; or contact the doctor or coroner to request a copy of the death certificate with listing of the cause of death and doctor signature to be kept in the resident's chart for filing and storage.	FIMAR13
C 882	02.203,02,a a. Patient's/resident's name and date of admission; previous address; home telephone; sex; date of birth; place of birth; racial group; marital status; religious preference; usual occupation; Social Security number; branch and dates of military service (if applicable); name, address and telephone number of nearest relative or responsible person or agency; place admitted from; attending physician; date and time of admission; and date and time of discharge. Final diagnosis or cause of death (when applicable), condition on discharge, and disposition, signed by the attending physician, shall be part of the medical record. This Rule is not met as evidenced by: Based on closed record review and staff interview, it was determined the facility failed to ensure a final diagnosis, or cause of death, was provided by the attending physician and documented in the medical record. This was true for 1 of 1 closed records (#8) reviewed. Findings include: Resident #8 was admitted to the facility on 4/16/09. The resident died in the facility on	C 882		

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C 882	Continued From page 3 12/28/12 On 2/14/14 at about 3:45 p.m., Resident #8's closed record was reviewed. However, a final diagnosis, or cause of death, was not included. The Administrator and the DON were informed on 2/14/13 at 5:00 p.m. a final diagnosis or cause of death was not included in the record. The Administrator stated he was not aware the record needed to include a final diagnosis or cause of death.	C 882	What measures will be put in place or what systemic change will you make to ensure that the deficient practice does not reoccur. As part of the final filing for a resident chart, the Medical Records Director will contact the doctor to document a final diagnosis in the chart for discharge; or contact the doctor or coroner to request a copy of the death certificate with listing of the cause of death and doctor signature to be kept in the resident's chart. The Medical Records Director will verify the receipt of the death certificate or documentation of a final diagnosis prior to filing the resident's chart for storage. How the corrective action(s) will be monitored to ensure the deficient practice will not recur? A QA audit will be completed by the DON or ADON to check all deceased resident charts for a death certificate or doctor discharge note for a final diagnosis or cause of death listing. These audits will begin 3/11/13 and will be done once (1) a week for four (4) weeks, then once (1) a month for six (6) months. All monitoring will be documented and retained. Deficiencies in this practice will be reported to the QA committee for review to determine if further actions are necessary.	