



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
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CERTIFIED MAIL: 7009 0820 0000 2798 7298

March 30, 2011

Roger A. Parker, Administrator
Idaho Falls Care & Rehabilitation Center
3111 Channing Way
Idaho Falls, ID 83404

Provider #: 135107

Dear Mr. Parker:

On **March 16, 2011**, we conducted an on-site follow-up revisit and complaint investigation to verify that your facility had achieved and maintained compliance. We had presumed, based on your allegation of compliance, that your facility was in substantial compliance as of **March 2, 2011**. However, based on our survey conducted **March 16, 2011**, we found that your facility is not in substantial compliance with the following participation requirements:

F281 42 CFR § 483.20(k)(3) Professional Standards of Quality
F314 42 CFR § 483.25(c) Pressure Sores

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.** 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 copy of the Post-Certification Revisit Report, Form CMS-2567B, listing deficiencies that have been corrected is enclosed.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **April 12, 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 corrected action will be completed.

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

As noted in the letter of February 17, 2011, following the Recertification and State Licensure survey of February 4, 2011, we have already made the recommendation to the Centers for Medicare and Medicaid Services (CMS) for Denial of Payment for New Admissions and termination of the provider agreement on **August 4, 2011**, if substantial compliance is not achieved by that time.

Remedies effective with this survey:

Continuation of the Denial of Payment for new Medicare/Medicaid admissions until substantial compliance is achieved and verified by the survey agency.

The Department is immediately imposing the following remedies as authorized by CMS:

Directed In-service Training - All to be conducted by Department-approved health care professional(s) from outside the SunBridge Healthcare organization.

1. An in-service on pressure ulcer prevention, identification, assessment, care planning, interventions and documentation. All licensed nurses employed by the facility must attend this in-service.

2. An in-service on the basics of medication administration to include the five rights. All licensed nurses employed by the facility must attend this in-service.
3. An in-service on physician order transcription. This must include processes to ensure the order is clear, the correct order is transcribed and the MAR accurately reflects the physician's medication orders. All staff involved in physician order transcription must attend this in-service.
 - **The Department must approve the presenter(s) prior to conducting the training.**
 - All required training sessions must be completed prior to the date the facility alleges substantial compliance.
 - Please send written notification to 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 a complete roster of staff members who attended.

Weekly Monitoring Reports

The facility is required to submit weekly monitoring reports to the state survey agency. These reports are to be completed by Teri Bonar, R.N., Division Director of Clinical Operations. The first of these reports is due with the Plan of Correction. These monitoring reports must address the status of system improvements for:

1. Pressure ulcer identification, care and documentation. The report is to include all residents with current pressure ulcers, all stages and the status of each. The report must include location, staging and measurement of each wound.
2. Medication errors, investigation and process improvement. The report is to include all medication errors, the investigation of cause and steps taken to prevent reoccurrence.

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.

STATE LICENSURE ACTIONS effective with the date of this letter (**March 30, 2011**): None

Roger A. Parker, Administrator
March 30, 2011
Page 4 of 4

If you believe the 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. You may also contest scope and severity assessments for deficiencies, which resulted in a finding of SQC or immediate jeopardy. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

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

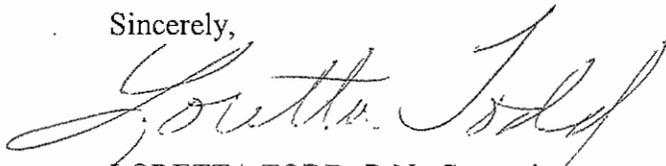
go to the middle of the page to **Information Letters - Long Term Care** section and click on **State** and select the following:

2001-10 Long Term Care Informal Dispute Resolution Process
2001-10 IDR Request Form

This request must be received by **April 12, 2011**. If your request for informal dispute resolution is received after **April 12, 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 on-site follow-up revisit. If you have any questions or concerns, please contact this office at (208) 334-6626.

Sincerely,



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

LT/dmj

Enclosures

cc: Jerilyn McClain, CMS Regional X

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

PRINTED: 03/30/2011
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 R 03/16/2011
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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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(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
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{F 000}	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the follow up and complaint investigation survey of your facility.</p> <p>The surveyors conducting the survey were:</p> <p>Lorna Bouse, BSW, Team Coordinator Marcia Key, BSN, WOCN</p> <p>Survey Definitions: ADL = Activities of Daily Living ADON = Assistant Director of Nursing BFS = Bureau of Facility Standards CP = Care Plan CNA = Certified Nurse Aide DON = Director of Nursing IDT = Interdisciplinary Team IPN = Interdisciplinary Progress Note LN = Licensed Nurse MAR = Medication Administration Record MDS - Minimum Data Set PUDF = Pressure Ulcer Documentation Form TAR = Treatment Administration Record WCN = Wound Care Nurse</p>	{F 000}	<p>“This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Idaho Falls Care & Rehabilitation Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency.”</p>	
{F 281} SS=D	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</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 a public complaint received on 3/15/11, staff interview, record review and review of facility event reports it was determined the facility did not provide nursing care which met professional standards of quality, when incorrectly transcribing</p>	{F 281}	<p>F281 Resident # 28 was discharged on 3/25/11 and no longer resides at the center.</p> <p>Medication labels were compared to the physician orders by the Pharmacy RN on 3/24/11 to ensure the correct dose was available for administration.</p>	

APR 1 2011
FACILITY COMPLIANCE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Roger R. [Signature]</i>	TITLE <i>Interim Administrator</i>	(X6) DATE <i>04-08-11</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 281}	<p>Continued From page 1</p> <p>a medication order for Ambien. In addition, nurses did not compare administration directions on the medication packaging label with the Medication Administration Record, before administering Ambien to 1 of 7 sampled residents (#28) reviewed for medication errors. Resident #28 received an incorrect dosage of Ambien which was also given at the wrong frequency. Findings include:</p> <p>The complainant alleged, on 3/15/11, that a resident of the facility had received the wrong dose and/or frequency of the medication Ambien.</p> <p>Resident #28 was admitted to the facility on 2/22/11 with diagnoses of Parkinson's disease with related dementia, hypothyroidism, congestive heart failure, and syncope with history of falls.</p> <p>The resident was admitted from a hospital with physician's orders that included, "Ambien strength 10 dose 0.5 oral bedtime." However, the resident's physician documented a prescription, dated 2/22/11, that ordered "Ambien 5 mg [one by mouth every] bedtime [as needed] insomnia."</p> <p>The March 2011 physician's orders recapitulation (RECAP) documented an order for, "Ambien (Zolpidem Tartrate) 10 mg Tablet by mouth (oral)-Night shift Everyday: Q HS." Directions included to monitor for side effects, and the medication was to be given for insomnia. The order was dated 2/22/11. This was the same for the RECAP for February 22 to 28, 2011.</p> <p>The MAR for February 2011 documented the resident had received Ambien 10 mg every night from 2/23/11 to 2/28/11. The start date for the order was 2/22/11. There was no documentation</p>	{F 281}	<p>Licensed nurses were re-educated prior to 4/7/11 by an outside pharmacy consultant on medication administration to include the five rights of medication administration, transcription of physician orders and ensuring the Medication Administration Record and medication card reflects the physician order. The Director of Nursing and/ or designee will complete medication pass observations to ensure medication is administered as ordered. The Director of Nursing and/ or designee will review physician orders for transcription to the administration record.</p> <p>Director of Nursing and/or designee will complete three audits per week for three months of licensed nurse medication administration observation and new order transcription. POC and audits will be reviewed by the facility PI Committee for compliance and trends and make recommendations as necessary for 3 months or until resolved.</p> <p>Compliance date: 4/1/11</p>	

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{F 281}	<p>Continued From page 2</p> <p>that indicated why the medication had not been given on 2/22/11.</p> <p>The MAR for March 2011 documented the resident had received Ambien 10 mg every night from 3/1/11 to 3/8/11. After 3/8/11 a note documented, "See New Order 3/9/11." A new order on the MAR was dated 3/9/11 and documented, "Ambien, by mouth, 5 mg, Q HS as needed. Start Date: 3/9/11." The resident had not received any Ambien since 3/8/11.</p> <p>A facility "Event Report" was dated 3/8/11 and documented the following: "When resident (#28) was admitted on 2/22/11 there was an order from the hospital for Ambien 10 mg PO QHS and a written script for Ambien 5 mg PO Q bedtime PRN. The order was not clarified and the first order for 10 mg QHS was transcribed to the MAR. From 2/23/11 until 3/7/11 according to the narcotic record only 5 mg was given per night until 3/8/11 when [LN-1] RN noted the discrepancy between what was on the MAR and what was being given to resident and gave the resident a full dose of 10 mg. Later in the shift [name] RN found the two conflicting orders and reported it to the DON promptly." NOTE: The event report was incorrect as the hospital ordered the Ambien at 5 mg, versus 10 mg. The confusion was perhaps due to the way the hospital order was documented, "Ambien strength 10 dose 0.5 oral bedtime." This was also a routine order to be given each night when the physician ordered on 2/22/11, "Ambien 5 mg [one by mouth every] bedtime [as needed] insomnia." The resident should have received the medication by request if needed.</p> <p>The event report had a copy of the physician's</p>	{F 281}		

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{F 281}	<p>Continued From page 3</p> <p>prescription order, dated 2/22/11, that documented the resident should have received 5 mg on a prn basis. The event report also had a copy of the bubble pack that was dispensed by the pharmacy. The label on the package documented, Ambien 5 mg, to be given as needed at each bedtime for insomnia. This matched what the physician prescription order documented.</p> <p>The DON was interviewed on 3/15/11 at approximately 9:20 am. The DON was asked to explain how the medication error for Resident #28 had occurred. The DON indicated it was incorrectly transcribed from the hospital orders when the resident was admitted. It was then incorrectly transcribed to the MAR and it did no good to compare them, as they were both incorrect. The surveyor asked how the order came to be labelled correctly on the bubble dispense package. The DON stated that the pharmacy had to have the actual prescription order from the doctor and that is what they had received, which resulted in the correct label on the bubble dispense package. The surveyor asked if a standard of practice for the nurses was to look at the order on the packaging and compare it with the MAR before administering the medication. The DON stated that was what should have been done.</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</p>	{F 281}		
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{F 281} Continued From page 4 routine."

{F 281}

{F 314} 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES
SS=D

{F 314}

F314
Resident #27's wound on the heel was assessed by the licensed nurse on 3/10/11. The physician was notified and treatment orders were obtained on 3/10/11.

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.

Licensed nurses completed skin observations on 3/23/11. Medical records were reviewed by the Director of Nursing and/ or designee on 4/6/11 to ensure interventions were in place and documented for those identified.

This REQUIREMENT is not met as evidenced by:
Based on a complaint from the public received by the BFS on 3/15/11, staff interview, review of the facility's Event Management System form (incident and accident form), and record review, it was determined the facility failed to ensure a resident, admitted to the facility on 2/10/11 with a reddened right heel, was assessed, monitored, and had preventative measures in place to prevent further deterioration of the heel. On 3/10/11 it was discovered that the resident had developed a blister Stage II pressure ulcer to the site. This was true for 1 of 5 residents sampled for pressure ulcers (#27.) Findings include:

Licensed nurses were re-educated prior to 4/9/11 to the Pressure Ulcer Prevention Program by an outside Registered Nurse wound care consultant. The training included pressure ulcer prevention, identification, assessment, care planning interventions and documentation. Department managers will round to monitor for pressure ulcer preventative devices as care planned. Pressure ulcers are reviewed weekly by the Director of Nursing and/ or designee for wound status and treatment, and current interventions in place.

On 2/4/11 a recertification survey was conducted

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{F 314}	<p>Continued From page 5</p> <p>at the facility. F314 was cited. According the the facility's Plan of Correction for F314, "...Ambassador rounds will be completed to monitor for preventative devices. Pressure ulcers are reviewed weekly by the Director of Nursing for status of wound, treatment,..and to ensure that weekly wound rounds are completed. Documentation will be completed on the 'Pressure Ulcer Documentation Form,' weekly...DNS [Director of Nursing Services] 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...Residents with current pressure ulcers and at risk for skin breakdown are reviewed in...meeting by the IDT [Interdisciplinary Team] for status of wounds, treatments & interventions in place..." The facility alleged compliance on 3/2/11.</p> <p>The complainant alleged an identified resident was recently admitted to the facility with a reddened heel. Staff did not continue to assess or document the reddened area. On 3/10/11, the resident's heel was observed to have a black area.</p> <p>During the follow-up survey on 3/15-16/11, Resident #27's record was reviewed to determine if the facility corrected the F314 deficient practice as of their allegation date of 3/2/11.</p> <p>Resident #27 was admitted to the facility on 2/10/11 following hospitalization for right hip fracture which required surgical hemiarthroplasty.</p> <p>The Nursing Assessment form, dated 2/10/11, documented under the section,</p>	{F 314}	<p>Documentation will be completed on the "Pressure Ulcer Documentation Form" weekly. The care plan(s) will be reviewed and updated to reflect the current status and interventions as indicated.</p> <p>New admissions and new pressure ulcers will be reviewed at the clinical stand up meeting for completion of skin assessments, orders for identified areas and interventions. The Director of Nursing and/ or designee will complete three audits per week for three months of residents with pressure ulcers and high risk for skin breakdown to ensure interventions are in place and care planned accordingly. The POC and audits will be reviewed at monthly PI meeting for compliance and trends and make recommendations as necessary for three months or until resolved.</p> <p>Compliance date: 4/11/11</p>	
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{F 314}	<p>Continued From page 6</p> <p>Integumentary/Feet, that the resident had a "Red" right heel. There was no description identifying if the red area blanched or did not blanch, which would have identified the area as a Stage I pressure/friction injury. There was no measurement of the redness, no indication if the heel area was boggy upon palpation, and no pain assessment of the red heel. There was no documented evidence that staff re-evaluated the redness within the hour of its discovery to determine if the red area persisted.</p> <p>The Federal guidance in F314 states, "Stage I pressure ulcers may be difficult to identify because they are not readily visible and they present with greater variability. Advanced technology (not commonly available in nursing homes) has shown that a Stage I pressure ulcer may have minimal to substantial tissue damage in layers beneath the skin's surface, even when there is no visible surface penetration. The Stage I indicators identified below will generally persist or be evident after the pressure on the area has been removed for 30-45 minutes...Stage I - 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: Skin temperature (warmth or coolness); Tissue consistency (firm or boggy); Sensation (pain, itching); and/or a defined area of persistent redness..."</p> <p>Resident #27's Norton Plus Pressure Ulcer Scale form, dated 2/10/11, documented the resident scored "10." A score of 10 or less indicated "high risk," for the development of pressure ulcers, according to the form.</p>	{F 314}		

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{F 314}	<p>Continued From page 7</p> <p>The record also contained a Skilled Charting Guidelines Tool, dated 2/10/11, which contained the section Pressure Ulcers/Wounds. The word "Wounds" was circled and there was a handwritten entry, "Rt [Right] hip." There were no other areas circled or entries made in this section of the form.</p> <p>Resident #27's Wound Care Plan, initiated on 2/10/11 and revised on 2/23/11, identified: "Alteration in Skin Integrity r/t [related to] Surgical wound to right hip. Interventions:..Pressure reducing/relieving devices as ordered...Weekly skin assessment per protocol..."</p> <p>The Skin Care Plan, initiated 2/10/11 and revised on 2/23/11, identified: "Potential for skin breakdown related to: decreased mobility s/p [status post] hip...Interventions:...Observe skin every shift for s/s of potential skin breakdown (e.g. redness/dyscoloration or open area)..Weekly skin assessment..." NOTE: The care plan did not direct staff to ensure the resident's heels were off-loaded to prevent pressure/friction after the resident was evaluated at "high risk."</p> <p>The following documentation on Resident #27 was obtained from the IPNs, TARS, CPs, PUDF, and the Event Management System Report (incident/accident.) NOTE: There was additional documentation in the facility's wound treatment book, entered on one IPN form, which was provided to the survey team upon request on 3/16/11, at 8:40 am. For clarification in this report, each entry from this form was identified as IPNSC (Skin Checks.) In addition, except when noted, none of the entries recorded the time of the assessment entry.</p>	{F 314}		

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

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FORM APPROVED
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{F 314}	<p>Continued From page 8</p> <p>IPN: *2/10/11, at 3:30 pm: "...Has orders for physical therapy. [One] assist [with] transfers...Uses abductor pillow...Dressing to R hip dry/intact. Denies pain at this time..." NOTE: There was no documentation of the status of the resident's red heel.</p> <p>IPNSC: *2/11/11: "Reddened areas on feet bilat[eral.] Purple areas on elbows bilat. No other skin issues noted." NOTE: The entry did not specifically address the resident's right "red" heel to document that the red area had resolved.</p> <p>IPN: *2/11: There were three entries made, however, there was no documentation that a skin assessment was performed. The last entry documented, "...Resident repositioned." NOTE: There were no entries for 2/12 or 2/13.</p> <p>IPN: *2/14: "...Skin warm dry [no] edema..."</p> <p>IPNSC: *2/14: "Skin [check]...Excoriation noted on L [Left] dorsal side of foot. No other skin issues noted."</p> <p>IPN: *2/15: "skin warm dry, [no] edema noted..."</p> <p>*2/16: There was no skin assessment documented.</p> <p>TAR: *2/16: The Weekly Skin Check identified "I" = "INTACT."</p> <p>IPN: *2/17: "...No c/o [complaints of] pains...skin pink and warm..."</p> <p>*2/18: "...Skin w/d [warm/dry]...Abd [abductor] pillow between her legs..."</p> <p>*2/18: "NOC [night shift]...Resident to have abductor when [up or down.]...skin pink and</p>	{F 314}		
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{F 314}	<p>Continued From page 9</p> <p>warm." *2/19: There were two entries, however, no skin assessments. *2/20, 2/21, 2/22: "...Skin warm dry [no] edema noted..." *2/23, at 10:00 pm: "...Skin pink and warm. Must have abductor wedge between legs @ all times..." TAR: 2/23: The Weekly Skin Check identified, "I." IPNSC: *2/23: "Skin [check]. Excoriation to L feet resolved. No other skin issues noted..."</p> <p>On 2/23/11, a second Norton Plus Pressure Ulcer Scale evaluation was performed. The score was "12" which identified the resident was no longer at "high risk."</p> <p>IPN: *2/24: "Edema in legs...Sees [Physician]...Received order for TED hose for edema in BLE [bilateral lower extremities]." *2/25, at 8:00 pm: "...Made sure wedge in place...Resident [no] c/o pain. Skin pink and warm." *2/26. There were two entries, however, there was no skin assessment. *2/27: "...Skin warm dry 2+ edema BLE non-pitting. 2/28, 3/1, 3/2, "...Skin warm dry..." TAR: 3/2: The Weekly Skin Check identified, "I." IPNSC: 3/2: "Skin [check]...Skin [check, no] new skin issues noted." IPN: *3/3, 3/4: There was no skin assessment. *3/5 at 8:00 pm, and 3/6 at 9:00 pm: "...Skin pink and warm..."</p>	{F 314}		

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{F 314}	<p>Continued From page 10</p> <p>*3/7, 3/8: "...Skin warm dry [no] edema..."</p> <p>*3/9: "...Legs & feet edemetous [sic] - tight TED hose..."</p> <p>*3/10: "...Skin warm dry. 3+ pitting edema BLE...." TAR:</p> <p>*3/10: The Weekly Skin Check identified, "N" = NOT INTACT".</p> <p>Event Management System (incident/accident) report:</p> <p>*3/10, at 2:00 pm:</p> <p>**Injury: Stage II" was marked.</p> <p>**Describe the circumstances of the event and what actions, if any, have been taken lately: Skin discoloration on right heal [sic], measures 3.6 cm [centimeters] x 1.5 cm. Blister in the center. Dry skin to foot. LAL [Low Air-Loss] mattress put in place, float heel in bed. Foam heel lifts boots ordered.</p> <p>*Last modified by [name of DON] on 3/10/2011 [,] 11:08:45 PM. EVENT: In-House acquired pressure ulcer was selected."</p> <p>*Report Preparer [Name of staff LN]...Location: Other. Other desc [description]: Wound. Cause: Improper Procedure. Injury: Stage II....Care plan updated: Yes..."</p> <p>IPNSC:</p> <p>3/10: "Skin [check]. New skin issue noted. Shallow dry skin discoloration on R heal [sic] measures 3.6 x 1.5. Color is brown and white and skin is very dry."</p> <p>PUDF:</p> <p>*3/10: "Site: R heel. Date of Onset: 3/10/11.</p> <p>*Present at Admission: Yes. Stage: 2." NOTE: This documentation conflicted with the admission nursing assessment, dated 2/10/11, which documented only a "red" area to the right heel, and each IPN and TAR which contained no documentation of any pressure-related injury to the right heel, until 3/10.</p>	{F 314}		

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{F 314}	<p>Continued From page 11</p> <p>*"Wound Measurements: Length, 3.6 x Width, 1.5 cm. Depth: [No]</p> <p>*Undermining Present: [No.] Tunneling Resent: [No.]</p> <p>*Odor: [No.] Exudate in Wound: [No.]</p> <p>*Wound Bed Tissue Type.." NOTE: This section was left blank although the wound was identified as a Stage II.</p> <p>*"Condition of Surrounding Skin: Warm, edema. Evidence of Wound Related Pain: [No.]"</p> <p>NOTE: The 3/10/11 documentation was the only entry on this form. The form was not signed.</p> <p>CP:</p> <p>*3/10: "Clean right heel [with] NS [Normal Saline] and cover [with] Optifoam q [every] 3 days. Float heels. LAL [Low Air-Loss] mattress."</p> <p>TAR: NOTE: This one TAR was located in the wound treatment book.</p> <p>*3/10: "Clean right heel with NS [Normal Saline] and cover with Optifoam q [every] 3 days." The wound care was performed on 3/10 and 3/13/11. The next scheduled dressing change was on 3/16/11.</p> <p>TAR:</p> <p>*3/11: The Weekly Skin Check identified, "N" = NOT INTACT."</p> <p>IPN:</p> <p>*3/11: "...2+ edema BLE..."</p> <p>*3/12: "Resident has 3+ pitting edema to bilateral LE...D/C'd [Discontinued] TED hose D/T [due to] R heel wound...Will continue to monitor."</p> <p>*3/12, at 11:30 pm: "...pitting edema +3 x 2 legs...Skin pink and warm."</p> <p>CP:</p> <p>3/13: "Podus boots bilateral heels on @ all times." The direction to "float heels" was marked "DC" (discontinued) on 3/13/11.</p> <p>IPNSC:</p> <p>3/13: "TED hose DCd. Border [not decipherable]"</p>	{F 314}		
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{F 314}	<p>Continued From page 12</p> <p>applied. Podus boots to protect R heal.[sic.]" This was the last entry on this form.</p> <p>IPN: *3/13, at 11:30 pm: "...Skin pink and warm...Resident's heels bridged. Will continue to monitor." *3/14: "...Skin warm dry 4+ edema noted. Res[ident] has Podus boots on..." *3/15: "...Skin warm dry. 4+ edema BLE..." NOTE: This was the last entry. There was no documentation of daily dressing checks to monitor for any strike-through drainage, nor assessment of the surrounding skin for increased redness. There was no ulcer assessment on 3/13/11 when the dressing was changed.</p> <p>On 3/16/11 at 9:00 am, the surveyor interviewed the wound care nurse (WCN.) The WCN indicated she had not yet performed the dressing change. The surveyor informed the LN that observation of Resident #27's heel ulcer needed to be arranged, with permission of the resident.</p> <p>At 10:30 am, the WCN and the surveyor entered the resident # 27's room. The resident granted permission for the surveyor to observe the ulcer dressing change. The resident was lying on a Low Air-Loss air mattress. The bed was in a very low position. Her heels were floated on pillows. There was no dressing on her right heel and no dressing noted in the trash can.</p> <p>The surveyor asked the WCN if she intended to measure the ulcer. She stated, "We only measure one time a week. Do you want me to measure it?" The surveyor stated, "Yes." NOTE: The only previous ulcer measurement was on 3/10/11, six days prior. The WCN left the room to obtain a measuring guide. At this time the DON entered</p>	{F 314}		
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{F 314}	<p>Continued From page 13 the room to assist the WCN.</p> <p>After the WCN returned, she and the DON washed their hands, the WCN gloved, and cleansed the right heel ulcer as the DON held the resident's right leg slightly elevated. The surveyor asked the WCN if the old dressing had been removed earlier when the resident had been showered. The WCN stated, "Yes." The surveyor asked the WCN if the CNAs showed her the old dressing. She stated, "No."</p> <p>During this time, with the bed in the very low position, the entire right heel ulcer site could not be observed by the surveyor. The DON noticed the multiple attempts by the surveyor to adequately observe the heel. The DON asked the WCN if she wanted the bed elevated. The WCN stated, "I'm okay." At this point the WCN removed the gloves, re-washed her hands, re-gloved, and started to apply the dressing. The surveyor stopped the WCN and again asked her if she intended to measure the ulcer. The WCN stated she had forgotten to get the measuring guide. She removed her gloves, washed her hands and left the room, returning with the measuring guide. During her absence, the DON lowered the resident's leg and put the bed in a higher position, making it possible for full view of the resident's heel. The WCN washed her hands and gloved, then proceeded to measure the ulcer.</p> <p>The WCN stated, "It measures 1.9 by 1.9 cm." The WCN laid the measuring guide down and started to re-dress the ulcer. The surveyor asked the WCN to describe the ulcer/site. She stated, "It's tan to off-white in the middle. The top is pinkish red." The surveyor asked the WCN if she considered the ulcer to be open in any area. She</p>	{F 314}		
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{F 314}	<p>Continued From page 14</p> <p>stated, "There's about 0.2 cm of granular tissue." The surveyor prompted the WCN to describe the ulcer edges. She stated, "Dark brown edges, about 75%." The surveyor further prompted the WCN to describe the surrounding intact skin. She stated, "The surrounding skin is warm and healthy pink." At this point the WCN applied the dressing then applied the Podus boots to the resident's lower extremities. The surveyor did not hear if the WCN asked the resident if she was experiencing any pain during the ulcer care.</p> <p>NOTE: The WCN and DON did not record the ulcer description while in the resident's room. The surveyor recorded the findings at the time the WCN performed the assessment on the surveyor's form.</p> <p>The resident's right heel ulcer appeared consistent with the formation of a blister which had dried. The edges had only a thin layer of darkened brown dry skin. There was no evidence of deep tissue injury. The surveyor did not observe any granulation tissue or any open areas within the ulcer borders which would identify the ulcer as Stage III.</p> <p>On 3/16/11, at 12:30 pm, the surveyor interviewed the DON and the regional RN consultant. The surveyor asked the DON if the WCN was certified in wound care management. The DON stated, "No." The consultant and DON were informed that at the time of the ulcer dressing change on Resident #27, the WCN had not planned on measuring the right heel ulcer. The DON stated that the WCN would have measured the ulcer. The surveyor informed the DON that prior to the DON entering the resident's room the surveyor had asked the WCN if she was going to measure the ulcer, and the WCN stated she had not</p>	{F 314}		

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{F 314}	<p>Continued From page 15 planned to do so.</p> <p>The surveyor also informed the RN consultant and DON that Resident # 27's documentation identified the resident was admitted to the facility with a reddened heel, however, there was no immediate follow-up assessment of the site to identify if the reddened area resolved or deteriorated. There was no evidence on the TAR or in the resident's record of the "every shift skin checks" to monitor for skin breakdown, as per the care plan. The regional RN consultant stated that the previous DON recently, "Left without notice." The current DON acknowledged that the right heel pressure ulcer developed after the facility's allegation of compliance date, 3/2/11.</p> <p>The DON was again interviewed at 3:10 pm. She was asked if Resident #27, who was at risk for the development of pressure ulcers, was reviewed by the IDT, as per the facility's plan of correction for all residents at risk. The DON provided the IDT note for the resident which documented only one meeting, which was held on 2/23/11. This note contained no documentation of the resident's right heel or any preventative measures taken to prevent the development of pressure ulcers. The DON acknowledged this was the only IDT entry for this resident.</p> <p>The facility had not corrected the previously cited F314. The facility alleged correction on 3/2/11, but the failed practice continued.</p>	{F 314}		

Bureau of Facility Standards

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{C 000}	<p>16.03.02 INITIAL COMMENTS</p> <p>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.</p> <p>The following deficiencies were cited during the follow up and complaint investigation survey of your facility.</p> <p>The surveyors conducting the survey were:</p> <p>Lorna Bouse, BSW, Team Coordinator Marcia Key, BSN, WOCN</p> <p>Survey Definitions: ADL = Activities of Daily Living ADON = Assistant Director of Nursing BFS = Bureau of Facility Standards CP = Care Plan CNA = Certified Nurse Aide DON = Director of Nursing IDT = Interdisciplinary Team IPN = Interdisciplinary Progress Note LN = Licensed Nurse MAR = Medication Administration Record MDS - Minimum Data Set PUDF = Pressure Ulcer Documentation Form TAR = Treatment Administration Record WCN = Wound Care Nurse</p>	{C 000}	<p>“This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Idaho Falls Care & Rehabilitation Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency.”</p>	
{C 789}	<p>02.200,03,b,v</p> <p>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;</p>	{C 789}	<p>C 789 See plan of correction for F314</p>	

APR 11 2011
FACILITY/STAFF

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE *Interim Administrator* (X6) DATE *04/08/11*

STATE FORM 6899 2JFW12 If continuation sheet 1 of 2

Bureau of Facility Standards

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{C 789}	Continued From page 1 This Rule is not met as evidenced by: Please refer to F314 as it addresses the facility's failure related to the development of pressure ulcers.	{C 789}		
{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 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 F281 as it addresses medication administration.	{C 798}	C 798 See plan of correction for F281	



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

April 26, 2011

Roger A. Parker, Administrator
Idaho Falls Care & Rehabilitation Center
3111 Channing Way
Idaho Falls, ID 83404

Provider #: 135107

Dear Mr. Parker:

On **March 16, 2011**, a Complaint Investigation survey was conducted at Idaho Falls Care & Rehabilitation Center. Marcia Key, R.N. and Lorna Bouse, L.S.W. conducted the complaint investigation. A total of 20 survey hours were required to complete this investigation in conjunction with the facility's follow-up revisit.

The identified resident's record was reviewed, as well as four additional records relating to the allegation of pressure ulcers and six records relating to the allegation of medication administration errors.

The facility's Event Management System reports (incident/accident/medication error investigation reports) were reviewed for the period after the facility alleged compliance on March 2, 2011.

The acting Administrator, Director of Nursing, Regional Nurse Consultant and the wound care nurse were interviewed.

Observation was made of the identified resident's right heel ulcer.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00004971

Roger A. Parker, Administrator
April 26, 2011
Page 2 of 3

ALLEGATION #1:

The complainant stated an identified resident entered the facility with a red heel. Skin checks did not address this. On March 10, 2011, the resident's heel had a black area.

FINDINGS:

Based on staff interviews, review of the facility's Event Management System form and record reviewed, it was determined the facility failed to ensure the identified resident, admitted to the facility on February 2, 2011, with a reddened right heel, was assessed, monitored and had preventative measures in place to prevent further deterioration of the heel. On March 10, 2011, it was discovered that the resident had developed a blister Stage II pressure ulcer to the site.

The facility was cited at F314 for this failed practice.

CONCLUSIONS:

Substantiated. Federal and State deficiencies related to the allegation was a recitation of deficiencies cited at the annual recertification survey of February 4, 2011.

ALLEGATION #2:

The complainant stated an identified resident had a medication error related to Ambien. The medication error was related to the wrong dose and frequency for administration of the medication. The error had continued for approximately ten days and only recently been discovered.

FINDINGS:

The facility provided an event report, dated March 8, 2011, which documented a medication error for the identified resident related to the medication Ambien. The medication orders had been transcribed incorrectly and nurses had not compared the label on the bubble package with the orders on the medication administration records to ensure there was no discrepancy. In this case, the medication administration record was transcribed incorrectly and the label on the packaging was correct. The medication was given incorrectly for fourteen days.

The facility was cited a federal deficiency F281 related to nursing standard of practice.

CONCLUSIONS:

Substantiated. Federal and State deficiencies related to the allegation was a recitation of deficiencies cited at the annual recertification survey of February 4, 2011.

Roger A. Parker, Administrator
April 26, 2011
Page 3 of 3

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

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

Sincerely,

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

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

LKK/dmj