



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 7328

April 8, 2013

Todd A. Russell, Administrator
BridgeView Estates
1828 Bridgeview Boulevard
Twin Falls, ID 83301

Provider #: 135113

Dear Mr. Russell:

On **March 29, 2013**, a Recertification and State Licensure survey was conducted at BridgeView Estates 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 a widespread deficiency that constitutes no actual harm with potential for more than minimal 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) and on or before the "Opportunity to Correct" (listed on page 3). **Please provide ONLY ONE completion date for each federal and state tag in column (X5) Completion Date, to signify when you allege that each tag will be back in compliance.** WAIVER RENEWALS MAY BE REQUESTED ON THE PLAN OF CORRECTION. After each deficiency has been answered and dated, the administrator should

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sign both Form CMS-2567 and State Form, Statement of Deficiencies and Plan of Correction in the spaces provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **April 22, 2013**. Failure to submit an acceptable PoC by **April 22, 2013**, may result in the imposition of civil monetary penalties by **May 13, 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.

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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*.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS), if your facility has failed to achieve substantial compliance by **May 3, 2013 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **May 3, 2013**. A change in the seriousness of the deficiencies on **May 3, 2013**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **May 3, 2013** includes the following:

Denial of payment for new admissions effective **June 29, 2013**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **September 29, 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, 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. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

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If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **March 29, 2013** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the noncompliance at the time of the revisit, if appropriate.

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

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

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

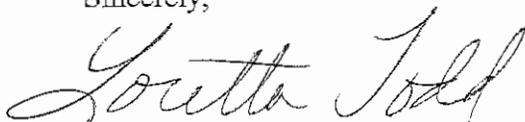
- BFS Letters (06/30/11)

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

This request must be received by **April 22, 2013**. If your request for informal dispute resolution is received after **April 22, 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,



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

LT/dmj
Enclosures

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 135113	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 3/29/2013
NAME OF PROVIDER OR SUPPLIER BRIDGEVIEW ESTATES		STREET ADDRESS, CITY, STATE, ZIP CODE 1828 BRIDGEVIEW BOULEVARD TWIN FALLS, ID	
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		
F 281	<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:</p> <p>Based on observation and staff interview, it was determined the facility failed to ensure an LN adhered to professional standards of quality when 1 of 3 LNs pre-initialed medications as administered before the medications were actually administered. This was true for 1 of 5 residents (#18) during medication pass observations. The failed practice created the potential for harm to the resident from a possible medication error. Finding included:</p> <p>Note: Information Letter #97-3, dated April 16, 1997: The Medication Distribution Technique Clarification To Informational Letter, 96-14, from the Bureau of Facility Standards, stated, "The issue arose when the Board of Nursing received information that the long term care facility staff were signing medications as given at the time of the medication preparation, not after the resident actually received the medication. .the Board's expectation, and the accepted standard of practice, is that licensed nurses document those things they have done, not what they intend to do."</p> <p>On 3/26/13, at 12:15 AM, LN #5 was observed as she drew up Novolog insulin 11 units (8 units were scheduled and 3 units were per sliding scale) for Resident #18 and initialed the medication as administered on the resident's MAR. The LN then administered the insulin medication per subcutaneous (SQ) injection into the resident's abdomen.</p> <p>LN #5 was interviewed immediately after the injection. The LN confirmed she had initialed the Novolog insulin as administered before she actually administered it. She stated, "I initialed it before I gave it, and should have initialed it after I gave the insulin."</p> <p>On 3/28/13 at 5:45 PM, the Administrator and the DON were informed of the issue. However, no other information or documentation was received from the facility which resolved the issue.</p>		

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

The above isolated deficiencies pose no actual harm to the residents

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

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FORM APPROVAL
OMB NO. 0938-0397

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135113	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/29/2013
NAME OF PROVIDER OR SUPPLIER BRIDGEVIEW ESTATES			STREET ADDRESS, CITY, STATE, ZIP CODE 1828 BRIDGEVIEW BOULEVARD TWIN FALLS, ID 83301		
(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 recertification survey of your facility. The surveyors conducting the survey were: Karen Marshall, MS, RD, LD Team Coordinator Monica Nielsen, QMRP, MED Karla Gerleve, RN Amy Jensen, RN Lorraine Hutton, RN, QMRP Survey Definitions: ADL = Activities of Daily Living ADON = Assistant Director of Nursing BIMS = Brief Interview for Mental Status CAA = Care Area Assessment CNA = Certified Nurse Aide DON = Director of Nursing FDA = Food and Drug Administration LN = Licensed Nurse MS = Maintenance Supervisor MAR = Medication Administration Record MDS = Minimum Data Set assessment OCD = Obsessive Compulsive Disorder RN = Registered Nurse SBP = Systolic Blood Pressure TAR = Treatment Record	F 000	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.		
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone	F 164	<p style="text-align: center;">RECEIVED APR 22 2013</p> <p style="text-align: center;">FACILITY STANDARDS F164</p> <p>Specific Residents</p> <p>Resident #17 is having his privacy protected while vital signs are being taken.</p> <p>Other Residents</p> <p>All residents have the potential to be affected. Residents are having their privacy protected while vital signs are being obtained. Audits are being completed to ensure compliance.</p>		

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

TITLE

(X6) DATE

Tom Kissen

Executive Director

4/19/13

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 164	Continued From page 1 communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.	F 164	Systemic Changes Staff inserviced on ensuring that privacy is protected while doing vital signs. New students in the building will have this training as part of their facility orientation.		
	The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure a resident's specific blood pressure value was not disclosed in a public setting. This affected 1 of 14 (#17) residents sampled for privacy during treatments. This practice created the potential for the resident to experience feelings of embarrassment when individuals other than those providing treatments observed and heard specific medical information related to the resident. Findings included: Random Resident #17 was admitted to the facility		Monitoring Two times per week random resident audits will be completed by licensed nurses and nursing assistants starting 04/29/13 times two months to ensure privacy is being protected while having their vital signs taken. Audits will be conducted weekly by the nurse managers for 8 weeks starting 04/29/13 then monthly for 6 months to ensure compliance. Results of the audits will be reviewed with the DON/ED and taken to QAPI meeting monthly starting with the May meeting. Date of Compliance 05/03/2013		

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F 164	Continued From page 2 on 4/10/12 with multiple diagnoses including unspecified essential hypertension (HTN). The resident's quarterly 1/8/13 MDS coded moderately impaired cognition BIMS score of 7 and moderate to severe depression score of 17. The resident's 3/13 Physician's Orders (recapitulation) contained a 4/10/12 order for Labetalol hydrochloride 200 milligram tablet, one tablet by mouth every day. (Hold if SBP is less than 110) Diagnosis HTN. On 3/26/13 at 7:03 a.m., an individual was observed determining Resident #17's blood pressure (BP) while the resident was seated in a wheelchair next to the medication cart on the hallway where the resident resided. The individual was dressed in a dark colored uniform with a paramedic patch on the upper left sleeve. LN #3 was standing at the medication cart. After the individual determined the resident's BP, the individual stated out loud what the BP value was. LN #3 then wrote the BP value on the resident's MAR. LN #3 stated, "I have a student today." During this observation, numerous passersby were observed walking up and down the hallway. Resident #17's 3/13 MAR contained two areas related to the above identified medication order: one area for staff to document the administration of the medication at 8:00 a.m. every day, and another area for staff to document the resident's BP. On 3/28/13 at 11:45 a.m., the surveyor informed LN #1, who was the Unit Manager for Resident #17, of the individual determining the resident's	F 164			

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F 164	Continued From page 3 BP while the resident was in the hallway. The LN stated, "The resident's SBP is to be determined before each medication administration. The individual performing the BP check was a paramedic and must not have been aware of our policy to do treatments in privacy." On 3/29/13 at 11:45 a.m., the Administrator and the DON were informed of the observation. The facility did not provide additional information.	F 164			
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview, and review of the Facility's Self-Administration of Medications policy, the facility failed to ensure a resident was assessed by the interdisciplinary team and determined safe to self-administer medications and to store the medication in the room. This was true for 1 of 19 (#19) residents observed during the initial tour. This failed practice created the potential for the resident to be harmed by over medicating himself and the potential to cause harm to residents in the area related to the medications not being secured. Findings included: Resident #19 was admitted on 2/28/13, with multiple diagnoses including post inflammatory pulmonary fibrosis and pneumonia.	F 176	F176 Specific Residents Resident #19 has been discharged from the facility. Other Residents All residents have the potential to be affected. Audit has been done to ensure residents have been deemed safe to have medications at bedside if they do, and the medications are stored appropriately.		

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F 176	Continued From page 4 The resident's 3/7/13 admission MDS coded moderately impaired cognitive skills, BIMS score of 12, inattention continuously present and did not fluctuate, easily distracted, out of touch, difficulty following what was said, verbal behavioral symptoms directed towards others, and rejection of cares.	F 176	Systemic Changes Staff inserviced that before a resident has been deemed safe to self-medicate, the interdisciplinary team must assess and sign off on the Medication Self-Administration Review form and the medications must be stored in a secure area. Monitoring Audits of residents for self-administration of medications will be conducted weekly by the Nurse Managers for 8 weeks starting 4/29/13 then monthly for 6 months to ensure the policy is being followed. The audits will be reported to the QAPI meeting for 6 months starting in May. Date of Compliance 05/03/2013		
	During the initial tour on 3/25/13 at 12:50 p.m. Resident #19 was observed to have the following medications on his night stand: throat spray, nasal spray, mega red krill, ribose, and time-released energy pills. On 3/26/13 at 3:55 p.m. Resident #19 was in his room. The above identified medication were not on his night stand. Resident stated, "They got rid of them." On 3/28/13 at 3:45 p.m., the surveyor informed Unit Manager #1 (UM #1) of the above observation. The UM stated, "He [Resident #19] had a self administration assessment done and he was safe to self-administer and keep them [the medications] in his room." On 3/29/13 at 11:15 a.m. the facility provided the following documentation: 1) Their Policy for Self-Administration of Medication documented, in part, residents will be asked if they desire to administer their medication. If the answer is "yes" the interdisciplinary team must assess the resident's ability to perform this responsibility. The interdisciplinary team will consist of the "Director of Nursing, Medical Director, LPN medicine nurse, and the input of the primary caregiver."				

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F 176	Continued From page 5 [NOTE: The interdisciplinary team is not limited to just nursing staff.] All medication stored in the resident's room will be kept in a, "locked drawer or container. A key will be provided to both the resident and Charge Nurse." 2) Resident #19's "Medication Self-Administration Review" form dated 3/11/13 and signed by a licensed nurse. The "Self-Administration Review" form completed for the resident, was not the	F 176		
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F 241 SS=D	same form that was identified in the facility policy. The policy indicated that the resident would be asked if he wanted to self administer his medications but, the form provided did not have that question on it. In addition, the form had a section for interdisciplinary review which had not been completed, which would indicate that the interdisciplinary team had not determined the resident was safe to self administer medications at his bedside. 3) During the survey, on 3/28/13 at 3:45 p.m., and on two occasions after the survey the DON and Administrator had been requested to produce a physician's order for the resident to self administer medications. The facility provided an order on 4/4/13 at 3:00 p.m. The physicians's order documented the resident may have, "vitamins including MVI, Fish oil, omega red, etc. He may keep them at his bedside and take them himself." Based on the information provided by the facility, it was not evident the interdisciplinary team conducted a self-administration assessment of Resident #19 to determine he was safe to administer and store his medications in his room. 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY	F 241		
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F 241	<p>Continued From page 6</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility failed to enhance and maintain the dignity of 2 of 19 (#6 & #8) sampled residents. Resident #6's urinary bag was uncovered and clearly visible in the dining room and from the doorway of her room. Resident #8's gown and undergarments were up around her neck and covering her face during her bed bath, this resulted in her entire body being exposed. This failed practice had the potential to negatively affect the residents' self-esteem and/or self-worth. Findings included:</p> <p>1. Resident #8 was admitted to the facility on 7/18/12 with multiple diagnoses including depression with anxiety, and morbid obesity.</p> <p>Resident #8's 1/10/13 quarterly MDS coded cognitively intact with a BIMS score of 15, extensive two person assistance for bed mobility and dressing. Totally dependent on one person for bathing.</p> <p>Resident #8's ADL Care Plan identified the problem personal hygiene, bathing-prefers to have bed baths at this time. One of the problem approaches was "explain all procedures and purpose" prior to performing task and encourage self-performance. Resident #8 is preferring bed baths at this time to going to the shower room.</p>	F 241	<p>F241</p> <p>Specific Residents</p> <p>Resident #6 is having her dignity protected by covering her catheter bag at all times. Resident #8 is having her dignity protected by only having the body part exposed that the staff member is washing.</p> <p>Other Residents</p> <p>All residents have the potential to be affected. Other residents are having their dignity protected by covering catheter bags and only exposing the body part that is being bathed when receiving a bed bath.</p>	
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135113	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/29/2013
NAME OF PROVIDER OR SUPPLIER BRIDGEVIEW ESTATES			STREET ADDRESS, CITY, STATE, ZIP CODE 1828 BRIDGEVIEW BOULEVARD TWIN FALLS, ID 83301	
(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 241	Continued From page 7 On 3/26/13 at 3:30 p.m. CNA #7 was observed in Resident #8's room giving her a bed bath. The only article of clothing the resident had on was around her neck and face and appeared to be the top of her garments and a hospital gown. These clothing articles covered the resident's chin, mouth, cheeks, and nose. Her eyes and forehead were not covered. Resident #8 complained of being cold 3 times during her bed bath. The CNA did not verbally respond to Resident #8's complaint of being cold or cover the resident's exposed body until she finished the entire bed bath and dressed Resident #8. On 3/29/13 at 11:25 a.m. Unit Manager #2 (UM #2) was interviewed and asked if it was an acceptable standard of practice to have gown or garments around a resident's face with the rest of the resident's body exposed during a bed bath. The UM stated that it was, "not and only the part of the body being washed should be exposed." The Administrator and DON were informed of the issue on 3/28/13 at 5:45 p.m. No further information was provided. 2. Resident #6 was admitted to the facility on 2/14/13 and readmitted on 3/9/13 with diagnoses of Sacral Wound, Hypertension, Depression, and Atonic Bladder. On 3/26/13 at 8:20 AM in the Bridge Dining Room, Resident #6 was observed up in a wheelchair sitting at a table during the breakfast meal. An uncovered catheter bag was visible and attached to her lower left leg. At 11:00 AM, Resident #6 was up in a wheelchair sitting in her room in front of the doorway. An uncovered	F 241	Systemic Changes Staff has been inserviced to ensure that urinary bags are covered at all times. Staff inserviced when giving a resident a bed bath that they only expose the body part they are washing. Monitoring Licensed staff and nursing assistants to complete 3 times per week audits of random residents starting 04/29/13 to ensure catheter bags are covered and body is not exposed when receiving a bed bath. Nurse Managers to complete weekly audits starting 04/29/13 to ensure compliance. Results of the audits will be reviewed with the DON/ED and taken to the QAPI monthly meeting starting with the May meeting Date of Compliance 05/03/2013	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135113	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/29/2013
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F 241	Continued From page 8 catheter bag was visible and attached to her lower left leg. On 3/28/13 at 5:45 PM, the Administrator and DON were notified of the dignity issue of the catheter bag being visible to others. No other information was provided.	F 241		
F 253 SS-E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to provide housekeeping and maintenance services to maintain a sanitary, and comfortable interior. This affected 10 resident rooms (#s 424, 428, 438, 440, 442, 443, 448, 451, 452, 457), 1 of 3 dining rooms (Twin Falls dining room), and 2 of 3 halls (Medicare and Secondary halls). This deficient practice created the potential to negatively affect the residents' psychological well-being related to an environment that was not clean and comfortable. Findings included: During the initial tour on 3/25/13 at 12:50 p.m., the following was noted: 1. Resident room #438 curtain hardware was in the wall, but the window curtain was missing. 2. In resident room #s 440 and 442 the grout between the shower and bathroom floor was cracked. 3. In resident room #428, the wall behind the	F 253	<u>F 253</u> 1. Affected Residents The following repairs were made in resident areas: 438 has had the curtain replaced 440 and 442 have had the grout repaired. In 428, the wall behind the sprayer has been repaired. In rooms 448, 451, 452, 457, have had the moldings and door frames repaired. The rubber baseboards outside of 443 and 449 have been repaired. In room 442 the bathroom sink mounting was repaired and re-caulked. In the Twin Falls dining room, the damaged walls were cleaned or repaired. The wooden window seals were refinished to provide a cleanable surface.	

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NAME OF PROVIDER OR SUPPLIER BRIDGEVIEW ESTATES	STREET ADDRESS, CITY, STATE, ZIP CODE 1828 BRIDGEVIEW BOULEVARD TWIN FALLS, ID 83301
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F 253	<p>Continued From page 9</p> <p>sprayer and toilet was cracked and broken exposing sheet rock. The wall was cracked approximately 4 1/2 inches in length below the sprayer.</p> <p>4. In resident room #s 448, 451, 452, and 457, molding and/or door frames were loose or coming off.</p> <p>5. Rubber baseboard molding outside of room #443 and 449 was peeling away from the walls on the Medicare hall and Secondary hall.</p> <p>6. In resident room #442, the bathroom sink and caulking around the sink was loose and the sink moved up and down when pulled or pushed on.</p> <p>7. The Twin Falls dining room had approximately 7 feet of missing wallpaper border on the East wall. Approximately 3 1/2 to 4 feet from the floor there were pieces of missing wall paper on every wall. The walls below the wallpaper border were stained with food, fluid and debris. Three wooden windowsills were chipped and worn with visibly rough edges. The finish of each windowsill was extremely dull in appearance making the area a non-cleanable surface.</p> <p>On 3/28/13 at 10:55 a.m. the Maintenance Supervisor (MS) accompanied the surveyor during the environmental review and was informed of the above concerns. The MS said he was aware of the concerns in the Twin Falls dining room and had attempted to replace wallpaper border, but that particular border was no longer available and he had not been able to find any that would match the existing wallpaper. He also stated they were in the process of re-staining the chair rails, the windowsills would be re-stained.</p> <p>The surveyor showed the MS the bathroom sink</p>	F 253	<p>2. Other residents</p> <p>All residents have the potential to be affected. The Maintenance staff have completed facility rounds to identify and repair any other issues found in resident areas of the facility.</p> <p>3. Systematic changes</p> <p>Maintenance and housekeeping staff have been inserviced on requirements of a sanitary, orderly and comfortable environment.</p> <p>4. Monitoring</p> <p>Maintenance director/designee to Complete monthly rounds/audits to insure resident areas are kept sanitary, orderly, and comfortable. All identified issues will be repaired to meet required standards. Findings will be reviewed at monthly QA/PI meetings.</p> <p>Date of compliance 05/03/2013</p>	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135113	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/29/2013
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F 253	Continued From page 10 in resident room #442 with the loose caulking and loose sink. The MS stated the caulking needed to be redone. The MS stated the grout in resident room #s 440 and 442 between the shower and bathroom floor cracked as the building settled. On 3/28/13 at 5:45 p.m., the Administrator and DON were informed of the observations.	F 253			
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and interviews, it was determined the facility failed to: 1) Ensure a resident with skin ulceration received necessary assessment and treatment to promote healing. This was true for 1 of 6 sampled residents (#5) reviewed for high risk for pressure ulcers. 2) Consistently monitor orthostatic BP. This was true for 1 of 10 (#4) residents sampled for medication administration. This practice created the potential for Resident #5's skin condition to reoccur and worsen and Resident #4's orthostatic BP to drop to unacceptable levels. Findings included:	F 309	Specific Residents Resident #5 is receiving necessary assessment and treatment to promote healing of skin ulceration. Resident #4 ortho blood pressures were discontinued 3/27/13. Other Residents Other residents who develop skin ulcerations, have MD ordered dressings or MD ordered orthostatic blood pressures, or have prn anti itch cream could be effected from this practice. Those with ulcerations will receive assessments and treatment to promote healing. Proper dates and signatures will be documented on the assessments. Those residents with MD ordered Orthostatic blood pressures will be documented per MD orders.		

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F 309	Continued From page 11 1. Resident #5 was admitted to the facility on 6/24/09 and was readmitted on 3/15/13 with multiple diagnoses of Cerebrovascular Accident, Manic Disorder, Depressive Disorder, Anxiety, Obesity, Diabetes Mellitus, cellulitis, dermatitis, and sacral ulcer. Resident #5's most recent annual MDS assessment dated 5/22/12 coded, in part: * BIMS Score: 10 * frequently incontinent * yes for at risk for developing pressure ulcers * moisture associated skin damage (MASD) * pressure reducing device for chair * pressure reducing device for bed * application of nonsurgical dressings other than to feet * applications of ointments/medication other than to feet * Note: Turning and repositioning program was not checked Resident #5's most recent quarterly MDS assessment dated 2/13/13 coded, in part: * BIMS Score: 05 * frequently incontinent * yes for at risk for developing pressure ulcers * yes for does this resident have one or more unhealed pressure ulcers at stage 1 or higher * 2-number of unstageable pressure ulcers with suspected deep tissue injury(SDTI) in evolution * 2-number of these unstageable pressure ulcers that were present upon admission/entry or reentry * MASD * Pressure reducing device for chair * pressure ulcer care * application of nonsurgical dressing other than to	F 309	Systemic Changes Licensed staff inserviced on Ensuring MD ordered dressings are in place as ordered and anti itch cream is used as indicated if ordered prn. Licensed Staff also inserviced on initialing 24 hour skin checks and dating the body diagram assessment form. Licensed nurses inserviced on importance of doing and documenting Orthostatic Blood Pressures as ordered by MD. Monitor Nurse Managers to audit 24 hour skin checks for initials signifying completion and body diagram assessments for dates and signatures. Audits will be after each admission times 6 months. Wound nurse to audit that prn itch creams are used if indicated two times per week times one month then monthly times four months.		

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F 309	Continued From page 12 feet * applications of ointments/medications other than to feet The Resident's "Interim Care Plan" dated March 15, 2013, identified pressure ulcer and cellulitis and stated "Refuses to lay in bed despite education 3/21/13" and "Scratches skin chronically 3/21/13". Interventions include "repositioning, pressure reduction mattress, personal cushion to recliner 3/21/13, sees dermatologist frequently 3/21/13 and chronic fungal rash to buttocks 3/21/13". Resident #5's care plan that was in the chart from the previous admission identified the problem "Risk for Pressure Ulcers" on 11/17/2011 which stated "[Resident #5] is at risk for developing a pressure ulcer, Readmitted with 2 SDTI's 11/05/12 to buttocks * related to immobility-CVA with hemiparesis *immobility-CVA with hemiparesis *DM (diabetes mellitus), moisture related denuded areas, and scratching at his skin. Non compliance with pressure reduction interventions. Approaches implemented included: Discuss non-compliance issues with [Resident #5] and educate about primary risk factors and prevention. Turn & reposition Q2 (every 2) hours or more frequently...." Resident #5's Treatment Record (TAR) for January, February, and March 2013 had a treatment for "Sarina anti-itch lotion as needed (for itchy skin)". All three months indicated this medication had never been initialed as being used. The Progress Notes for Resident #5 indicated the resident frequently scratched and created gouges to the area on his buttocks	F 309	Licensed staff to audit that dressings are in place as ordered 2 times per week times 2 months. Nurse Manager will audit that dressings are in place for 10 random residents as ordered one time per week times two months then weekly times 2 months then monthly times 2 months. Nurse Managers to audit one time per week that Orthostatic Blood pressures are documented as ordered. Audits to begin 4/29/13. Results of the audits will be reviewed with the DON/ED and taken to QAPI meeting monthly starting with the May meeting. Date of Compliance 05/03/2013		

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F 309	Continued From page 13 causing bleeding. (See Progress notes for 2/15/13, 3/5/13, 3/8/13, and 3/25/13). During interview with the Wound Care RN on 3/27/13 at 9:45 AM, the RN indicated the Sarina anti-itch cream would only have been applied if the resident asked for it. Resident #5 had impaired cognitive status and a diagnosis of a yeast infection on his buttocks. The documentation indicated consistent scratching on his buttocks.	F 309			
	There was no evidence nursing staff had proactively asked the resident at intervals whether he needed the anti-itch medication or had evaluated the possibility of requesting an order for the medication to be given routinely, rather than waiting for the resident to request it himself. Resident #5's Medication Record indicated: "Fluconazole (Diflucan) 100 MG by mouth on Thursdays. Resume after finishing 200 MG dose. Diagnosis: yeast infection" The Primary Hall Unit Manager RN/ADON was interviewed on 3/27/13 at 10:25 AM regarding Resident #5's itching and to his buttocks. The RN stated "scratching is the issue, not itching. He has a nervous disorder and it has something to do with his mental health. He has OCD. I know [Resident #5's name]. It's more of a behavior issue." When it was pointed out that there was no diagnosis of OCD in the record, the RN stated she would find the documentation of the OCD diagnosis. On 3/28/13 at 10:00 AM, the DON provided a Fax of a physicians order, dated 3/27/13 that stated "3. Note omission of OCD DX in more recent paperwork. Please re-add diagnosis." Note: Resident #5 was being treated for a yeast				

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F 309	Continued From page 14 infection in and surrounding the wound area on his buttocks. Resident #5's TAR dated March 2013 indicated a treatment for a "24 hour skin check due the day after admit" and March 16 (the day after admit) was outlined. The box on March 16th was blank and was not initialed as completed.	F 309			
	Resident #5's TAR dated March 2013 also had an order for the dressing, "mepilex border to buttocks, change every other day". This was ordered on 3/25 and was initialed off as complete on 3/25 and 3/26. There was also a order for "desitin ointment apply to buttock/sacral area twice daily. Dx cellulitis". Note: The Physician orders were to change the dressing every other day but apply the cream 2 times a day and the anti-itch cream as needed. Therefore, the dressing had to be removed to apply the creams and then reapplied. On 3/27/13 at 9:20 AM in the resident's bathroom, an observation was made of wound care to the resident's buttocks. CNA #4 and the Wound Care RN stood the resident at the bar in the resident's bathroom. When they pulled the resident's incontinent brief down to perform wound care, the surveyor noted that there was not a dressing in place on the resident's wound, and the dressing was not found. The surveyor asked where the old dressing was, and the RN replied "I don't know. I know [the LPN's name that worked the previous day] put one on yesterday and I put one on Monday. Sometimes it doesn't stick and it comes off". However, during interview with the Wound Care RN at 11:35 AM, on 3/28/13 AM, she indicated the dressings stuck on				

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F 309	<p>Continued From page 15</p> <p>well and were made to easily stick back on the resident after pulling them off to apply creams.</p> <p>The facility failed to ensure the physician's ordered dressing remained on the resident's wound, failed to initial a 24 hour physician ordered skin check, failed to date the body diagram assessment form, and failed to offer the resident an "as needed" (PRN) anti-itch cream for itching.</p>	F 309		
	<p>On 3/29/13 at 11:00 AM, the Administrator and DON were informed of the issue. On 4/1/13 additional information was received from the facility. However, no information or documentation was received that resolved these issues.</p> <p>2. Resident #4 was admitted to the facility on 7/21/12 with multiple diagnoses including orthostatic hypotension and a history of falls.</p> <p>Resident #4's 1/16/13 quarterly MDS coded moderately impaired cognition BIMS of 11 and history of falls.</p> <p>Resident #4's Falls Care Plan contained a 7/21/12 problem: potential for side affects from medication use related to orthostatic hypotension, significant and severe autonomic neuropathy with Shy-Drager syndrome. One of the problem approaches was monitor for side affects from medication use that may increase risk of falls.</p>			

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F 309	Continued From page 16 Resident #4's neurology office visits, 12/12/12 and 2/14/13 respectively, documented, in part, follow up for orthostatic hypotension Shy-Drager syndrome. Resident #4's 3/13 Physician's Orders (recapitulation) contained a 12/12/12 order, check orthostatic blood pressure (Ortho BP) every "Tuesday and Thursday."	F 309			
F 315 SS=D	Resident #4's 1/13 through 3/13 Treatment Records (TARs) contained in the far left hand column, Check Ortho BP every Tuesday and Thursday. The TARs also identified Tuesdays and Thursdays for staff to document the resident's Ortho BPs. On the following dates, the resident's Ortho BPs were not documented as determined: *1/8, 1/10, 1/17, 1/22, and 1/31/13 *2/26/13 *3/5/13 On 3/27/13 at 10:09 a.m., the surveyor reviewed the 3/13 MAR with LN #1. The LN stated, "We need to check the resident's Ortho BPs because of Shy-Drager syndrome. Nursing staff should check two times a week." The surveyor then informed the LN of the inconsistent documentation of Ortho BPs on the 1/13 and 2/13 TARs. The LN acknowledged the BPs were inconsistently monitored. On 3/29/13 at 11:45 a.m., the Administrator and the DON were informed of the finding. The facility did not provide any additional information. 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER	F 315			

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F 315	Continued From page 17 Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.	F 315	<p>F315</p> <p>Specific Residents Resident #7 does have an individualized toileting program.</p> <p>Other Residents Other residents have the potential</p>	
	<p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility failed to accurately assess and develop an individualized toileting program for 1 of 19 (#7) sampled residents. This had the potential for harm as incontinence can cause multiple medical issues including skin breakdown and excoriation. Findings include:</p> <p>Resident #7 was admitted to the facility on 11/9/12 with multiple diagnoses including congestive heart failure, liver disease, depression, ascites, and malnutrition.</p> <p>The resident's Admission MDS, dated 12/7/12, documented the resident required extensive assistance for transfers and limited assistance with ambulation. He required extensive assist by two for toileting and was frequently incontinent (coded 2) of bladder. There was no trial for a toileting program indicated.</p> <p>Resident #7's Care Plan for Incontinence, dated 02/20/13, documented: * Explain toileting program to the resident,</p>		<p>to be affected and will be assessed for a individualized toileting program if indicated by a score of 7-14 on urinary incontinence assessment.</p> <p>Systemic Changes</p> <p>Licensed Staff/Nurse Managers and Restorative Nurse have been inserviced to accurately assess and develop an individualized toileting program for residents if they score between 7-14 on the Urinary Incontinence Assessment if appropriate and desired by resident to promote continence. CNAS have been inserviced on following individualized toileting plans.</p>	

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NAME OF PROVIDER OR SUPPLIER BRIDGEVIEW ESTATES			STREET ADDRESS, CITY, STATE, ZIP CODE 1828 BRIDGEVIEW BOULEVARD TWIN FALLS, ID 83301		
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F 315	<p>Continued From page 18 including goals, voiding pattern and determined toileting schedule.</p> <ul style="list-style-type: none"> * Adjust toileting schedule PRN [as needed] if the resident's elimination pattern changes. * Assist resident to toilet before/after meals, [every] HS [hour of sleep], [every] 4 hours at night & prn [as needed] resident request. <p>A facility document "Assessment for Bowel and Bladder Training" dated 11/09/12, contained the following documentation:</p> <ul style="list-style-type: none"> * On page (1), his total assessment score was "13" and the assessment scale key documented "7-14 = Candidate for toileting, timed or scheduled voiding." * On page (2), the assessment scale key documented, "If score is 0-14: On admission, complete the Urinary Incontinence Assessment." The facility did not proceed to the Urinary Incontinence Assessment as indicated above. <p>A facility document dated 11/09/12, "Urinary Status Interview", documented overall the resident was occasionally incontinent of bladder and he indicated he used medications, pads, and briefs. The resident did indicate that he knew when he was incontinent because he could feel himself being damp or wet.</p> <p>03/28/13 at 3:55 p.m. UM #1 was interviewed and stated that Resident #7's incontinence was related to his elevated ammonia levels which caused "confusion." UM #1 was asked if Resident #7 was on a toileting program and she stated, residents are taken to the bathroom before/after meals, at bedtime, and as needed. UM #1 failed to answer definitively if the resident was on an individualized toileting program.</p>	F 315	<p>Monitoring</p> <p>Nurse Managers to audit Urinary Incontinent Assessments within 7 days of admission and if indicated by score of 7-14. Nurse managers to interview cnas and residents about patterns and set up individualized toileting plan for resident if appropriate and desired by resident to promote continence. Audits will continue for 6 months.</p> <p>Current residents will have their Urinary Incontinent Assessments and toileting plan reviewed and updated as indicated on their MDS schedule. Audits will start 4/29/13 and will continue for 6 months.</p> <p>Results of the audits will be reviewed with the DON/ED and taken to QA/PI meeting monthly starting with the May meeting.</p> <p>Date of Compliance</p> <p>05/03/2013</p>		

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F 315	Continued From page 19	F 315	F323		
F 323 SS=D	03/28/13 at 5:45 p.m. the Administrator and DON were notified. No further information was provided. 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on staff interview, medical record review, and Incident/Accident report review, it was determined the facility failed to ensure a resident's Care Plan was periodically re-evaluated and revised to determine adequate supervision/assistive devices were used for 1 of 19 (#7) sampled residents to reduce the risk of avoidable falls. There was potential for harm related to resident falls which could cause serious injury. Resident #7 was admitted to the facility on 11/9/12 with multiple diagnoses: Congestive heart failure, liver disease, ascites, depression, and malnutrition. The resident's Re-entry MDS, dated 12/07/12, documented the resident had the ability to express ideas and wants (coded 0), had the ability to understand others (coded 0), and had	F 323	Specific Residents Resident # 7 will have interventions for falls implemented, revised as appropriate including increased supervision. Current interventions have been reviewed.		
			Other Residents Other Residents who have falls are at risk due to this practice and will have interventions for falls implemented, care planned and revised as appropriate, including increased supervision. Systemic Changes Licensed staff and nurse managers Inservice to ensure that all interventions put in place related to falls are careplanned, implemented, and revised as needed. This inservice to include care planning when implementing increased supervision. CNAS inservice to ensure that interventions must be in place as ordered and to report to supervisor if interventions are not effective or resident refusing.		

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F 323	Continued From page 20 moderately impaired cognition with a BIMS of 10. The resident required extensive assist by two staff for transfers (coded 3) and one person physical assist for ambulation (coded 2). The resident's MDS, documented "yes" (coded 1), for did the resident have a fall anytime in the last month prior to admission/entry or reentry. The resident's Quarterly MDS dated 02/20/13, documented the resident had the ability to express ideas and wants (coded 0), had the ability to understand others (coded 0), and had moderately impaired cognition with a BIMS of 06. The resident required extensive assistance by one person for transfers (coded 2) and one person physical assist for ambulation (coded 2). The resident's MDS, documented "yes" (coded 1), for has the resident had any falls since admission/entry or reentry or the prior assessment. The resident's Fall Care Plan, dated 2/20/13, included the following approaches: low platform bed with Span America mattress, call light within reach, area free of clutter, wheelchair with anti-tip devices and self-locking brakes, extensive 1-2 person physical assist for transfers from bed to chair and back, ambulates with extensive 1 person assist, tab and pressure alarms at all times to bed and wheelchair and has bathroom door alarm. On 2/6/13, a hand written entry documented, encouraging non-skid socks at night. On 2/7/13, a hand written entry documented, keeping personal items close to bed. An undated hand-written entry documented "Resident wishes to be as independent as possible - so does not use call light."	F 323	Monitoring Nurse Managers to audit fall incidents to careplan and to resident room to ensure new interventions are implemented or interventions not working are revised, including increased supervision if applicable. Audits will occur after each fall Starting 4/29/13 times 6 months. Results of the audits will be reviewed with the DON/ED and taken to QAPI meeting monthly starting with the May meeting. Date of Compliance 05/03/2013		

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F 323	Continued From page 21 NOTE: Resident #7's Fall Care Plan did not contain information as identified in the fall investigations outlined below for the landing strip or the reacher. In addition, the Fall Care Plan did not address the need to increase staff supervision to reduce the risk of falls. Resident #7's Incident/Accident Data Entry Questionnaires were reviewed and documented several falls as summarized below. The facility failed to implement, monitor, and revise as appropriate, interventions including supervision, consistent with Resident #7's needs, to reduce the risk of avoidable falls, as follows: - 11/16/12 at 3:00 a.m.: Resident #7 was found sitting on the landing strip next to his bed. Resident #7 stated he was reaching for his urinal and slipped onto the floor. The Follow-Up & Recommendation Form, attached to the Questionnaire, documented " ...Alarms were on but res [Resident #7] had removed alarm clip... replace with sensor alarm & continue tab alarm ...Urinal to be placed a [at] beside [bedside]. Therapy to provide reacher to allow easier access to his belongings." - 11/18/12 at 2:44 a.m.: Resident #7 was found sitting on the landing strip next to his bed. He was holding onto the wheel of his wheelchair and trying to pull on the automatic safety brakes. He reported he was trying to move his wheelchair and get his walker to the bed so he could get up. His call light was within reach but he did not turn it on. He was assisted back onto his bed and checked for injuries. Abrasions were noted to his abdomen. Resident #7 reported that prior to	F 323			

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F 323	Continued From page 22 putting himself to the floor, he was reaching over the foot board looking for his address book. "He stated he was used to doing things on his own, and he didn't like having to ask for help." The Follow-Up & Recommendation Form, attached to the Questionnaire, documented "Defined Parameter mattress - bedside table closer to bed - Therapy to provide reacher."	F 323			
	<p>- 12/4/12 at 10:00 a.m.: Resident #7 was found sitting on the floor with his legs out in front of him. He stated "I dropped my diaper and sat down to get it." His attends was soiled. The Follow-Up & Recommendation Form, attached to the Questionnaire, documented, "Sensor alarm placed to room ...remove tab alarms - only keep pressure alarms ..."</p> <p>- 12/19/12 at 4:03 p.m.: Resident #7 was found sitting on the toilet and was bleeding from a pencil eraser sized wound to his right knee and had an abrasion to the top of his left hand. "Res [Resident #7] had been sitting in his w/c [wheelchair] a few minutes prior to being found on toilet." Resident #7 was unaware of how he got injured. The Follow-Up & Recommendation Form, attached to the Questionnaire, documented the environment was assessed for sharp edges and none were found. Under the section titled Follow-Up, it documented "...alarms have been helpful to staff to allow for cares before resident transfers."</p> <p>- 1/4/13 at 3:00 p.m.: Resident #7 was found with the top part of his back lying on the floor with his buttocks still in his wheelchair. Resident #7 stated he was rocking in his wheelchair and both brakes were locked at the time. The Follow-Up &</p>				

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F 323	Continued From page 23 Recommendation Form, attached to the Questionnaire, documented Resident #7 was educated to not lock the brakes and rock in his chair and anti-tip devices were applied to his wheelchair. A Post-Fall Screening Tool, dated 1/7/13 and attached to the Incident/Accident report, stated "Pt [Patient] screened today & noted significant cognitive changes [with] inability to follow directions & confusion ...Balance poor.	F 323		
	<p>Pt. [Patient] was not comprehending education regarding safety issues such as locking brakes [sic] getting A [assistance] for mobility & transfers. Unable to ambulate today."</p> <p>- 2/3/13 at 12:00 a.m.: Resident #7 was found on the floor sitting up next to his bed. He reported he was trying to get up and slid off the side of his bed onto his bottom. He had removed his tab alarm "So it wouldn't make any noise." The Follow-Up & Recommendation Form, attached to the Questionnaire, documented non-skid socks were applied and pressure alarms were added to his bed and wheelchair.</p> <p>- 2/9/13 at 4:42 p.m.: Resident #7 was found lying, curled up on his right side, on the bathroom floor. "He told me he got ran over by a wild buffalo. He then told me that he was trying to stand up, just to see if he could manage it." The Follow-Up & Recommendation Form, attached to the Questionnaire, documented "...pressure and tab alarms, landing strip next to bed ..."</p> <p>- 3/24/13 at 1:40 p.m.: Resident #7 was found on the floor between his closet and bed. The Follow-Up & Recommendation Form, attached to the Questionnaire, documented "Res. [Resident #7] transferred self from w/c [wheelchair] and was</p>			

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F 323	Continued From page 24 found on floor between closet and bed. [Increased] confusion noticed prior to fall." Resident #7's physician was notified and ordered ammonia levels be drawn on 3/25/13. Those levels were found to be high and Resident #7 was sent to the local emergency room for evaluation. Resident #7's Fall Risk Evaluations, dated 12/4/12, 2/9/13, 2/21/13, and 3/24/13 documented his score was "4" in the following areas: he had 3 or more falls during the last 90 days, he ambulated with problems and with devices, he had health conditions with risk factors, and took medications that had potential drug reactions. His overall total score was documented as 24 (a score of 10 or higher is considered at high risk for falls) on 12/4/12, 28 on 2/9/13, 22 on 2/21/13, and 26 on 3/24/13. UM #1 was interviewed on 03/28/13 at 3:55 p.m. she verbalized Resident #7's falls were directly related to his confusion caused by elevated ammonia levels. The surveyor asked what plan was in place for resident to prevent falls related to his confusion. UM #1 verbalized that staff would check on resident "more often" during these times. The facility failed to implement, monitor, and revise as appropriate, interventions including increased supervision, consistent with Resident #7's needs, to reduce the risk of avoidable falls. The Administrator and DON were informed on 3/28/13 at 5:45 p.m. No further information was provided.	F 323			
F 329 SS=D	483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	F 329			

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F 329	Continued From page 25 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. 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. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure a resident did not receive excessive medication dosage and was monitored for cardiac medication as ordered. This affected 1 of 11 (#17) residents sampled for administration and monitoring of medications. This practice created the potential for the resident to experience dangerously low blood pressures. Findings	F 329	F329 Specific Residents Resident #17 had the order d/c'd to monitor blood pressure before giving Labetelol on 4/18/13. Other Residents All residents that have MD orders to check blood pressure before giving medication have the potential to be affected by this practice. Systemic Changes Licensed staff inserviced to ensure that they are following MD orders to check blood pressure and follow parameters before they give the medication.		

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F 329	Continued From page 26 included: Random Resident #17 was admitted to the facility on 4/10/12 with multiple diagnoses including unspecified essential hypertension (HTN). The resident's quarterly 1/8/13 MDS coded moderately impaired cognition BIMS score of 7.	F 329	Monitoring Daily audits by Licensed nurses starting 04/29/13 times two months to ensure that they are following MD orders related to blood pressure checks	
	The resident's Cardiac Maintenance Care Plan identified the 4/10/12 problem, "[Resident #17] is on cardiac maintenance r/t dx HTN, and hx CVA [related to diagnoses of hypertension, and history of cerebrovascular accident.]" One of the problem approaches was, "Vital signs per MD orders..." The resident's 3/13 Physician's Orders (recapitulation) contained a 4/10/12 order for Labetalol hydrochloride 200 milligram tablet, one tablet by mouth every day. (Hold if SBP is less than 110) Diagnosis HTN. Random Resident #17's 1/13 through 3/13 MARs contained two areas related to the above identified medication order: one area for staff to document the administration of the medication at 8:00 a.m. every day, and another area for staff to document the resident's BP. On the following dates, the resident's SBP was not documented, as determined, prior to nursing staff administering the medication: *1/8, 1/16, 1/21, 1/22, and 1/31/13 *2/4, 2/5, 2/8, 2/9, 2/10, 2/15, 2/17, 2/24, 2/26, and 2/28/13 *3/1, 3/10, 3/15, and each day 3/18 through 3/25/13 On 3/26/13 at 7:03 a.m., an individual was		prior to medication administration. Audits will be conducted weekly by Unit Managers for 8 weeks starting 4/29/13 then monthly for 6 months to ensure compliance. Results of the audits will be reviewed with the ED/DON and taken to QAPI monthly meeting starting with the May meeting. Date of Compliance 05/03/2013	

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F 329	Continued From page 27 observed determining Random Resident #17's BP. The individual was dressed in a dark colored uniform with a paramedic patch on the upper left sleeve. The resident's SBP was determined to be above 110. Note: Please refer to F164 as it related to privacy during treatment. On 3/28/13 at 11:45 a.m., the surveyor reviewed the 3/13 MAR with LN #1. The LN stated, "It appears there were days in March 2013 when the resident's SBP was not determined as ordered. The resident's SBP is to be determined before each medication administration. When the SBP is less than 110, nursing staff should not administer the medication." The surveyor and the LN then reviewed the resident's Cardiac Maintenance Care Plan. The LN stated, "The care plan approach indicates vital signs per MD orders."	F 329			
F 371 SS=E	On 3/29/13 at 11:45 a.m., the Administrator and the DON were informed of the observation. The facility did not provide additional information. 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced	F 371	F371 Specific Residents Bridgeview Estates provides foods which are planned, prepared, and served under sanitary conditions. Sampled residents had the potential to be affected by the sanitizing solution being below the accepted parts per million. Once identified the bucket with the sanitizing solution below the required levels was discarded and a new container of sanitizer was installed and then the sanitizer container was refilled and tested to be at 200 ppm. This was done immediately upon identification of the infraction and ultimately reduced the risk for all residents at the facility.		

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F 371	Continued From page 28 by: Based on observation, record review, and staff interviews, it was determined the facility failed to ensure the sanitizing solutions in 1 of 2 buckets evaluated maintained the correct parts per million (ppm). This affected 16 of 19 (#s 1-13 & 17-19) sampled residents and had the potential to affect any resident who dined in the facility. This practice created the potential for	F 371	Other Residents All residents had the potential to be affected by the sanitizer solution being below the required levels. Dietary Supervisors frequently check to insure compliance with this requirement.	
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	cross-contamination of food and exposed residents to potential sources of pathogens. Findings included: On 3/25/13 at 12:55 p.m., the Director of Dietary Services (DDS) accompanied the surveyor during the initial tour of the facility kitchen. - At 1:00 p.m., two red plastic buckets containing quaternary sanitizing solution were evaluated for ppm. The test strip for one of the sanitizing buckets did not change color. The test strip registered "0 [zero]." The DDS asked Cook #6 to empty the red bucket and refill with sanitizing solution. Cook #6 took the bucket to the appropriate location in the warewashing room to refill the bucket. As the Cook began to fill the bucket with new solution, the DDS directed the Cook to look at the supply container under the counter. There was no liquid in the supply container. Staff immediately replaced the empty container with a new container of quaternary solution. A new bucket of sanitizing solution was made and tested at 200 ppm. The appropriate ppm range was, 125 to 400 ppm. The DDS stated, "The supply container must have just ran out before Cook #6 filled his bucket. We change the solutions in the buckets every 2 hours." On 3/29/13 at 11:45 a.m., the Administrator and		Systemic Changes To insure the deficient practice will not recur the Director of Dietary Services and the Registered Dietician will inservice all staff on the following procedures: A. Prior to filling each sanitizer bucket the dietary staff member will check to insure the sanitizer supply container is not empty. A new container will be replaced as needed. B. A freshly dispensed bucket of Sanitizer solution will be used each time the kitchen surfaces are being sanitized. A clean rag will be used with each newly dispensed/tested bucket of sanitizing solution. When not in use the sanitizer solution will be discarded.	
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135113	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/29/2013
NAME OF PROVIDER OR SUPPLIER BRIDGEVIEW ESTATES			STREET ADDRESS, CITY, STATE, ZIP CODE 1828 BRIDGEVIEW BOULEVARD TWIN FALLS, ID 83301	
(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 371 F 441 SS=D	Continued From page 29 the DON were informed of the observation. The facility did not provide any additional information. 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if 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. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of	F 371 F 441	C Skills testing will be done for all dietary staff to ensure a full understanding of dispensing, testing PPM and correct sanitizing of surfaces. Monitoring The Director of Dietary Services will monitor the overall sanitation of the kitchen during daily rounds. At this time, The Director of Dietary Services will check the appropriate sanitizing of surfaces is occurring. On the days the Director of Dietary Services is out of the facility this duty will be designated to a qualified Dietary Supervisor. The Registered Dietician will check compliance with this sanitizing procedure monthly during the audit review and will report results to facility administration. The director of Dietary Services will report results to the QA/PI committee monthly. Date of Compliance 05/03/2013	

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F 441	Continued From page 30 infection. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to use appropriate hand washing practices to reduce the spread of infections and prevent cross-contamination for 1 of 19 (#8) sampled residents. This failed practice created the potential risk for residents in the facility to spread infection from one resident to another. Findings included: Resident #8 was admitted to the facility on 7/18/12. She was admitted with multiple diagnoses including muscle weakness and morbid obesity. The resident's quarterly MDS dated 1/10/13 coded her as cognitively intact and she required extensive physical assistance of two or more persons for personal hygiene and dressing and total assistance of one person for bathing. The resident's ADL Care Plan identified the problem of self care deficit. One of the approaches was offer resident choice of clothing and provide extensive assistance with changing and dressing. On 3/26/12 at 3:30 p.m., CNA #7 was observed providing personal cares for Resident #8. The following was observed: * At 3:35 p.m., CNA #7 provided a bed bath to the resident and was wearing gloves. She walked	F 441	F441 Specific Residents Resident #8 is having Cares provided with Current standards of Infection Control Practice related to cnas changing gloves and washing hands. Other Residents All residents have the potential to be affected by this practice. Cares are being provided with Current standards of Infection Control Practice related to cnas changing gloves and washing hands.		

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F 441	<p>Continued From page 31</p> <p>over to the closet and with the same gloves on, placed her left gloved hand on the closet door. With her right gloved hand she reached into the closet and removed a clean adult incontinence brief. She then put the brief on the resident.</p> <p>* At 3:40 p.m. the CNA with the same gloves still on she removed the resident's nasal cannula from her nose.</p> <p>*At 3:45 p.m., the CNA removed the gloves and discarded them in the trash and did not wash her hands. She then grabbed a clean gown, garment top, and dressed the resident.</p> <p>* At 3:55 p.m., after she dressed the resident, the CNA applied lotion to the resident's arms and hands. The CNA did not wash her hands before she applied the lotion to the resident and did not wash her hands after.</p> <p>The current CDC (Centers for Disease Control and Prevention) website (<Http://www.cdc.gov>), an accepted professional standard, listed indications for handwashing that included but were not limited to:</p> <ul style="list-style-type: none"> · Before having direct contact with residents · After contact with a resident ' s intact skin (when taking blood pressure or lifting a resident) · After contact with body fluids · If moving from a contaminated-body site to a clean-body site during patient care · After contact with inanimate objects including medical equipment in the immediate vicinity of the resident · After removing gloves · After any direct contact with the resident <p>In addition, when the surveyor entered the room at 3:30 p.m. there were 3 visibly soiled wipes on the floor by the trash can and dirty linen piled on the floor.</p>	F 441	<p>Systemic Changes</p> <p>CNA Staff inserviced on indications for hand washing and when to change gloves to promote infection control practices to help reduce the spread of infection and cross-contamination while providing cares. Nursing Staff inserviced on not leaving dirty linen or soiled wipes on the floor.</p> <p>SDC or designee doing direct care observations of appropriate hand washing and gloving practices, as well as monitoring for clothes or soiled wipes on the floor.</p> <p>Monitoring</p> <p>SDC or designee is doing direct observation of appropriate hand washing and changing of gloves while nursing assistants are providing cares to residents 3 times per week for 8 weeks and then weekly for 3 months to ensure that appropriate hand washing/gloving practices are being used when nursing assistants are providing cares.SDC monitoring rooms for soiled linen or dirty wipes on floor during the observation audits. Observation audits will start 4/29/13.</p>	

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F 441	Continued From page 32 On 3/29/13 at 11:25 a.m., the surveyor informed UM #2 of the above identified observations. The UM stated it is not an acceptable practice to leave soiled gloves on and then touch the closet door, remove a clean attend from the closet, and remove the resident's nasal cannula from her nose.	F 441	Results of the audits will be reviewed with the ED/DON and taken to the QA/PI meeting starting with the May meeting. Date of Compliance 05/03/2013	
F 465 SS=F	On 3/29/13 at 11:45 a.m., the Administrator and the DON were informed of the observations. The facility did not provide any additional information. 483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, it was determined the facility failed to ensure the flooring in the food preparation area of the kitchen was maintained in a cleanable condition. This affected 16 of 16 (#s 1-13) sampled residents, 3 of 3 (17-19) random residents, and had the potential to affect all residents who dined in the facility. This practice created the potential to expose residents to disease causing pathogens. Findings included: On 3/27/12 at 11:23 a.m., the floor in the food preparation area of the facility's kitchen was an industrial type non skid material. There were more than 100 dents, dings, and indentations in	F 465		

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F 465	Continued From page 33 the floor surface. The original color of the floor appeared to have been a green, teal color at one time. There was a yellow, dingy discoloration over more than 75% of the floor surface. In addition, there appeared to be dark gray debris build-up around the edges of the floor surface near the reach in refrigerator and the food preparation area next to the stove, french fryer, and grill areas.	F 465	<p><u>F 465</u></p> <p>1. Affected Residents</p> <p>Sampled residents 16 of 16 and 3 of 3 random residents were affected by the deficient practice.</p> <p>2. Other residents</p>	
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	<p>Note: The yellow, dingy discoloration extended from the entrance of the kitchen down the hallway past the intersection where the medical records office, the Director of Dietary Services (DDS) office and the Twin Falls dining room were located. This was an area approximately 34 (thirty-four) feet in length. The hallway floor was made of a smooth, vinyl type material.</p> <p>On 3/27/13 at 11:27 a.m., the surveyor informed the DDS about the condition of the floor in the kitchen and the hallway coming out of the kitchen. The DDS stated, "We clean the kitchen floor every night. We are not able to get rid of the debris build-up and yellow discoloration on the floor in the food preparation area. The dings and indentations are from years of food preparation: dropped spoons, knives, pots and pans, large cans of food used in food preparation [number 10 cans], etc."</p> <p>On 3/27/13 at 11:28 a.m., the surveyor asked the Housekeeping Laundry Manager about the yellow, dingy discoloration on the surface of the hallway floor from the kitchen to the Twin Falls dining room. The Manager stated, "We cannot get the yellow discoloration off the vinyl flooring. We have tried and tried. We believe the</p>		<p>All residents who dine in the facility have the potential to be affected.</p> <p>The Maintenance staff have completed facility rounds to identify and repair any other flooring issues found in resident areas of the facility.</p> <p>3. Systematic changes</p> <p>Maintenance, Dietary and Housekeeping staff were inserviced on requirements of a safe, functional, sanitary and comfortable environment.</p> <p>The facility has committed to replace the affected kitchen floor with new flooring that meets sanitary requirements. All other flooring affected by the yellow discoloration will be stripped and cleaned to meet sanitary requirements. The floors within the approximate 34 feet identified that will not meet sanitary requirements will be replaced as required.</p>	
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F 465	Continued From page 34 discoloration is from the kitchen. As dietary staff walk around on the discolored floor in the kitchen, whatever is on the floor sticks to the bottom of shoes and then is carried out of the kitchen on shoes and discolors the hallway flooring." On 3/27/13 at 11:57 a.m., the surveyor requested the DON and the Regional Nurse Area Trainer observe the yellow discoloration extending down the hallway from the entrance of the kitchen to the entrance of the Twin Falls dining room. Both the DON and the RN acknowledged the vinyl hallway flooring had a yellow discoloration.	F 465	Bids on replacing flooring will be received by May 3 rd with a commitment from the Corporation to complete the work within 90 days of received bids. Plans will be put in place to insure that the Facility meal service continues without any issues thru the replacement process. 4. Monitoring	
F 514 SS=D	The 2009 FDA Food Code Chapter 4, subpart 202.16 Nonfood-Contact Surfaces indicated, "Nonfood-contact surfaces shall be free of unnecessary ledges, projections, and crevices, and designed and constructed to allow easy cleaning and to facilitate maintenance." On 3/29/13 at 11:45 a.m., the Administrator and the DON were informed of the finding. The facility did not provide additional information. 483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any	F 514	Maintenance director/designee to complete monthly rounds/audits to insure resident areas are kept safe, functional, sanitary, and comfortable. All identified issues will be repaired to meet required standards. Findings will be reviewed at monthly QA Meetings. Date of compliance 05/03/2013	

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F 514	Continued From page 35 preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure residents' medical records were accurate and complete. This was true for 4 of 16 sampled resident's (#s 5, 7, 13, & 16). The lack of accurate and complete documentation could affect the facility's ability to develop effective care programs, revise care programs, and as necessary, to respond to the changing status of the resident. Findings include:	F 514	F514 Specific Residents	
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	<p>1. Resident #13 was admitted to the facility on 8/17/12 with diagnoses including adult failure to thrive, acute pain, history of falls, and hypoxia.</p> <p>The resident's 11/20/13 Quarterly MDS assessment coded the resident was at risk for skin breakdown and pressure relieving devices would be used in the resident's bed and chair.</p> <p>Nursing Notes, dated 1/17/13, documented the resident was found with a, "2 X 2 PU" (Pressure Ulcer) on his sacrum. Pressure Ulcer Treatment Sheets documented the resident had a stage II PU on his sacrum between 1/17/13 and 2/1/13. The PU Treatment Sheet documented the wound was resolved on 2/1/13. However, Weekly Skin Checks performed by LN staff, documented the resident's sacrum was "clear" and without skin breakdown on 1/17/13 and 1/24/13.</p> <p>During an interview on 2/28/13 at 9:30 am, the</p>		<p>Resident #5, 7, 13 & 16 Resident #13&16 have discharged. Resident #5 skin checks are being signed and dated. Resident #7 has the month and year on his Behavioral Intervention monthly flow record and sliding scale insulin form.</p> <p>Other Residents All residents have the potential to be affected by this practice and will have weekly skin checks documented accurately, Medication administration records, treatment administration records, Behavioral Intervention monthly flow records and sliding scale insulin form will have the month and year on the form.</p>	
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F 514	Continued From page 36 facility's Wound Care Nurse (WCN) confirmed that Resident #13 developed a pressure ulcer in January 2013. She became aware of it on 1/17/13 and contacted the resident's physician. An air mattress and Mepilex dressings were initiated. The WCN stated the stage II PU appeared like a blister and "never opened." She stated the PU was healed by 2/1/13. When asked to review the Weekly Skin Care Sheets, dated 1/17/13 and 1/24/13, the WCN agreed that the buttocks/sacrum area were marked, "clear" on 1/17/13 and 1/24/13, and did not accurately reflect the resident's skin condition on those dates. 2. Resident #16 was admitted to the facility on 3/6/13 and discharged home on 3/13/13. The resident was admitted for physical therapy related to increased weakness and an unsteady gait. Following her admission to the facility, a medication administration record was developed for the resident. This record included her resuscitation status, tuberculosis testing results, monitoring pain every shift, and instructions for a puree diet with nectar thick liquids. However, this record did not indicate the month or year that it was initiated. In addition, there were two treatment records which also failed to document the month or year. These sheets provided care instructions to staff who were to document floating the resident's heels while she was in bed, doing peri-care every shift, applying Lubriderm moisturizer, and skin inspections. On 3/28/13 at 4:30 pm, these records were shown to the unit manager (UM) for the medicare hall. The UM acknowledge that the information on	F 514	Systemic Changes Licensed staff inserviced that skin assessments must accurately reflect the resident's skin condition, that medication records, sliding scale insulin, treatment records, and behavioral intervention flow record must have a month and a year on them. In addition Licensed nurses were inserviced to sign the treatment record after doing a 24-hour post admit skin assessment and when doing an admission skin assessment. Monitoring Health Information Manager or Designee will audit one time per week times 2 months then monthly times 4 months to ensure month and year are on the MAR, TAR, Behavioral intervention flow sheet And sliding scale insulin flow sheet. Nurse Managers to audit admission Skin assessments and 24 hour skin	

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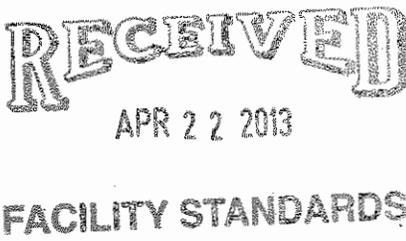
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F 514	Continued From page 37 the records was incomplete therefore making it difficult to know for the month/year the records were initiated. 3. Resident # 5 was admitted to the facility on 6/24/09 and was readmitted on 3/15/13 with multiple diagnoses including Cerebrovascular Accident, Manic Disorder, Depressive Disorder, Anxiety, Obesity, Hyperlipidemia, and Diabetes Mellitus, dermatitis, ulcer to his buttocks, and cellulitis. Resident #5's Treatment Record for March 2013 indicated a 24 hour skin check was due the day after admit, on March 16th. The March 16th box was boxed off but was blank indicating the 24 hour skin check was never performed. The admission body diagram form stated, "redness to bilateral buttocks, denodement[spelling]/pressure ulcer to left buttocks." This assessment was signed by an LPN, but was not dated. The Wound Care RN was interviewed on 3/27/13 at 9:45 AM. The RN stated "It looks like they just forgot to initial it" (The 24 hours skin check on the Treatment Record)." The Wound Care RN also indicated the admission body diagram was part of the "Initial Data Collection Tool" Note: There were several body diagrams for Resident #5 in the resident's chart. The facility failed to maintain clinical records for Resident #5 in accordance with accepted professional standards and practices which were complete and accurately documented. On 3/28/13 at 5:45 PM, the Administrator and	F 514	Checks for date and signature after each admission times six months. Wound nurse to audit accuracy of Weekly skin assessments of residents Having pressure ulcers two times per week times one month and weekly times 5 months. Audits will begin 4/29/13. Results of the audits will be reviewed with the ED/DON and taken to the QAPI meeting starting with the May meeting. Date of Compliance 05/03/2013		

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F 514	Continued From page 38 DON were informed of the documentation issue. No other information or documentation was received from the facility which resolved the issue. 4. Resident #7 was admitted on 11/09/12 with multiple diagnoses: Congestive heart failure, liver disease, depression, ascites, and malnutrition. Resident #7's record had two "Behavioral/Intervention Monthly Flow Records" which did not include the month or year on the form. Resident #7's record had a "Sliding Scale Insulin" form which did not include the month or year on the form. UM #1 was interviewed on 3/28/13 at 3:45 p.m. and asked to identify the month and year on each of the 3 forms. She looked at each form and stated that she could not identify the month and year.	F 514			

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 State licensure survey of your facility. The surveyors conducting the survey were:	C 000		
C 125	Karen Marshall, MS, RD, LD Team Coordinator Monica Nielsen, QMRP, MEd Karla Gerleve, RN Amy Jensen, RN Lorraine Hutton, RN, QMRP 02.100,03,c,ix Treated with Respect/Dignity ix. Is treated with consideration, respect and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; This Rule is not met as evidenced by: Please refer to F164-as it related to privacy during treatments. Please refer to F241 as it related to dignity.	C 125		5-2-13 @ 1540 PER DISCUSSION WITH ADMINISTRATOR ADD "REFER TO," TO C125 C125 - REFER TO F241 Refer to F164
C 325	02.107,08 FOOD SANITATION 08. Food Sanitation. The acquisition, preparation, storage, and serving of all food and drink in a facility shall comply with Idaho Department of Health and Welfare Rules, Title 02, Chapter 19, "Rules Governing Food Sanitation Standards	C 325		C325 Refer to F371

Bureau of Facility Standards

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

TITLE
Executive Director

(X8) DATE

4/19/13

Bureau of Facility Standards

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C 325	Continued From page 1 for Food Establishments (UNICODE)." This Rule is not met as evidenced by: Please refer to F371 as it related to the sanitizing solution.	C 325	5-2-13 @ 1540 PER DISCUSSION WITH ADMINISTRATOR ADD "REFER TO;" TO C361 C361 - REFER TO F465 Refer to F253	<i>A Jensen</i>
C 361	02.108,07 HOUSEKEEPING SERVICES AND EQUIPMENT 07. Housekeeping Services and Equipment. Sufficient housekeeping and maintenance personnel and equipment shall be provided to maintain the interior and exterior of the facility in a safe, clean, orderly and attractive manner. This Rule is not met as evidenced by: Please refer to F465 as it related to the floor in the kitchen and the hallway flooring adjacent to the kitchen. Please refer to F253 as it relates to a sanitary, clean, orderly, and attractive environment.	C 361		
C 666	02.150,02,c Quarterly Committee Meetings c. Meet as a group no less often than quarterly with documented minutes of meetings maintained showing members present, business addressed and signed and dated by the chairperson. This Rule is not met as evidenced by: Based on record review and staff interview, it was determined the facility's Infection Control Committee meetings did not include the Pharmacist and Medical Director and that the Committee met at least quarterly. This had the potential to impact all of the residents, staff, and visitors in the facility. The findings include: 1. The facility's Infection Control reports and	C 666	State Tag C666 Specific Residents and Other Residents Potential to effect all residents, staff and visitors to the building. Systemic Changes The Interdisciplinary Management Team has been inserviced that the Infection Control Meeting must occur no less than quarterly and must have the Pharmacist and Medical Director attend. Pharmacist and Medical Director were informed they needed to be at the meeting. First meeting with all required attendees was held 4/11/13.	

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C 666	Continued From page 2 documented evidence of attendees was reviewed from 3/2012 through 2/2013. For the year 2012, there was no documented evidence that a meeting was held during the second quarter (April, May, June) of the year. Additionally, there was no documented evidence that the Pharmacist and Medical Director attended any of the meetings in 2012.	C 666	Monitoring Regional Director of Clinical services to audit monthly first month and quarterly times four for pharmacy and Medical Director attendance at Infection Control Meeting. Results of the audits will be Reviewed with the ED/DON and taken to the QAPI meeting starting with the May meeting.	
	For the year 2013, a meeting was held on 2/13/13. However, there was no documented evidence that the Pharmacist and Medical Director attended the meeting. When asked about the meetings, the DON stated on 3/28/13 at 11:31 a.m., "The Pharmacist and Medical Director have not attended for about a year." The facility failed to ensure the Pharmacist and Medical Director attended Infection Control Committee meetings and that the meetings were held at least quarterly.		Date of Compliance 05/03/2013	
C 672	02.150,03,c Staff Knowledge of Infection Control c. Exhibited knowledge by staff in controlling transmission of disease. This Rule is not met as evidenced by: Please refer to F441, as it relates to infection control.	C 672	C672 Refer to F441	
C 762	02.200,02,c,ii When Average Census 60-89 Residents ii. In SNFs with an average occupancy rate of sixty (60) to eighty-nine (89) patients/residents a	C 762	State Tag C762 Specific Residents Residents #1-13 and all residents who reside in the building.	

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C 762	Continued From page 3 registered professional nurse shall be on duty for each a.m. shift (approximately 7:00 a.m. - 3:00 p.m.) and p.m. shift (approximately 3:00 p.m. to 11:00 p.m.) and no less than a licensed practical nurse on the night shift. This Rule is not met as evidenced by: Based on review of the facility's Three Week Nursing Schedule 3/3/2013 through 3/23/13, and staff interview, it was determined the facility failed to ensure a registered professional nurse was on duty for the PM shift for 4 out of 21 days. This affected 13 of 13 (#'s 1-13) sampled residents and all residents who resided in the facility. Findings included: The 3/3/13 through 3/23/13 Nursing Schedule provided evidence that the PM shift for the following dates did not have 8 hours of RN coverage. Below were specific dates and hours in which a RN was present on the PM shift. *3/3/13, 4.0 hours *3/9/13, 3.0 hours *3/10/13, 3.0 hours *3/22/13, 7.5 hours On 3/27/13 at 9:40 AM, the Staff Coordinator was interviewed regarding the as worked schedule for 3/3/13 through 3/23/13. She stated, "I did not have a RN that worked those evenings". On 3/27/13 at 4:40 PM, the Administrator and DON were informed of the finding. The facility provided no additional information.	C 762	Other Residents As above Systemic Changes The Staffing Coordinator has been inserviced that a RN must be on duty for day shift (6am-2pm) and evening shift (2pm-10pm). The Staffing Coordinator was inserviced that she must inform the DON/ED if she cannot find RN coverage. Monitoring DON/ED will audit schedule 2 times weekly for two months, weekly times 2 months and monthly times 2 months to ensure there is a RN scheduled for 6am-2pm and 2pm -10pm. Audits will begin 4/29/13. Results of the audits will be Reviewed with the ED/DON and taken to the QAPI meeting starting with the May meeting.	
C 788	02.200,03,b,iv Medications, Diet, Treatments as Ordered iv. Delivery of medications, diet	C 788	Date of Compliance 05/03/2013	

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C 788	Continued From page 4 and treatments as ordered by the attending physician, dentist or nurse practitioner; This Rule is not met as evidenced by: Please refer to F309 as it related to not following doctor orders.	C 788	C788 Refer to 309	
C 790	02.200,03,b,vi Protection from Injury/Accidents vi. Protection from accident or injury;	C 790	C790	
C 795	02.200,03,b,xi Bowel/Bladder Evacuation/Retraining xi. Bowel and bladder evacuation and bowel and bladder retraining programs as indicated; This Rule is not met as evidenced by: Please refer to F315, as it relates to Incontinence training.	C 795	Refer to F323 C795 Refer to F315	
C 797	02.200,03,c Documentation of Nursing Assessments c. Nursing staff shall document on the patient/resident medical record, any assessments of the patient/resident, any interventions taken, effect of interventions, significant changes and observations and the administration of medications, treatments and any other services provided. Entries shall be made at the time the action occurs and shall be signed by the person making the entry and shall provide the time and date of	C 797	C797 Refer to F514	

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C 797	Continued From page 5 the occurrence. At a minimum, a monthly summary of the patient's/resident's condition and reactions to care shall be written by a licensed nursing staff person. This Rule is not met as evidenced by: Please refer to F 514 as it refers to completion of assessments, accuracy of assessments and dating of assessments.	C 797		
C 835	02.201,02,i i. No medication shall be in the possession of the patient/resident unless specifically ordered by the physician on the patient's/resident's medical record, and in no case shall exceed two (2) units of dosage. All such medications shall be individually packaged by the pharmacist in units of dose, labeled with the patient's/resident's name, unit of dose, and date of distribution. The charge nurse shall maintain an inventory of these drugs on the patient's/resident's medical record. This Rule is not met as evidenced by: Refer to F176 as it related to Self-Administration of Medication.	C 835	C835 Refer to F176	
C 881	02.203,02 INDIVIDUAL MEDICAL RECORD 02. Individual Medical Record. An individual medical record shall be maintained for each admission with all entries kept current, dated and signed. All records shall be either typewritten or recorded legibly in ink, and shall contain the following:	C 881	C881 Refer to F514	

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C 881	Continued From page 6 This Rule is not met as evidenced by: Please refer to F514 as it relates to Resident Records-Complete/Accurate/Accessible	C 881		