



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

May 9, 2011

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

Provider #: 135107

Dear Mr. Parker:

On April 27, 2011, an on-site follow-up revisit of your facility and a Complaint Investigation survey was conducted to verify correction of deficiencies noted during the Follow-Up revisit and Complaint Investigation survey conducted on March 16, 2011, to the originating Recertification and State Licensure survey of February 4, 2011. Idaho Falls Care & Rehabilitation Center was found to be in substantial compliance with health care requirements as of **April 14, 2011**.

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

Due to the fact that your facility is now back in substantial compliance, submission of weekly monitoring reports is no longer required.

Thank you for the courtesies extended to us during our follow-up revisit. If you have any questions, concerns or if we can further assist you, please call this office at (208) 334-6626.

Sincerely,

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

LKK/dmj
Enclosures



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

Provider #: 135107

Dear Mr. Parker:

On April 27, 2011, a Complaint Investigation survey was conducted at Idaho Falls Care & Rehabilitation Center. Lorna Bouse, L.S.W. and Arnold Rosling, R.N., Q.M.R.P. conducted the complaint investigation. This complaint was investigated in conjunction with a follow-up revisit to an annual recertification survey. The records of nine residents were reviewed, including the record of the identified resident.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00005023

ALLEGATION #1:

The identified resident was admitted in November 2010 from the hospital. The resident had fallen at home and sustained a hip fracture. The caller indicated the resident is cognitively intact.

The complainant stated that on April 11 or 12, 2011, the identified resident was observed during evening meal and was not being assisted with his supper. The complainant did not know names of any staff on duty. The resident had a recent weight loss of five pounds and since his admission in November 2010 the resident had lost "a lot of weight." The complainant was not sure what the total weight loss had been.

FINDINGS:

The identified resident was not admitted to the facility until February 16, 2011. He was admitted after being discharged from a hospital where he was treated after he fell at home and fractured his hip. The hospital records documented that his spouse brought him in to the emergency room after a fall outside by his home. The spouse informed the physician that over the past month the identified resident's gait had become increasingly unsteady and he had fallen at least five times in that time. In addition, the spouse said the identified resident's memory seemed to be getting worse.

The Minimum Data Set (MDS), version 3.0, assessment is required by the federal government to be completed in skilled nursing homes. The section completed for the identified resident related to cognition indicated the resident was cognitively impaired.

On April 26, 2011, the survey team entered the facility unannounced at 5:00 pm. An observation tour was completed for all halls and residents were observed in and out of their rooms. The surveyors then went to the dining room to observe dinner. Some residents were assisted by visiting family members. Residents who needed assistance were receiving help from staff. Staff was adequate in number for meal set up and help. One family member stated that a nurse was always in the dining room when the meals were served. The identified resident was no longer in the facility and could not be observed.

The following day, Wednesday, April 27, 2011, the survey team noted the same conditions in the dining room for breakfast and lunch. In addition, staffing numbers were requested for a week during the timeframe indicated in the complaint. The facility exceeded the state's minimum staffing requirements.

The resident had lost weight since his admission on February 16, 2011. Hospital records indicated the resident had lost weight while in the hospital. The resident had been assessed for nutrition upon admission. The facility documented he was under weight and the amount of food he was consuming was not adequate to keep weight on. The facility's dietitian immediately recommended enhanced meals to increase the amount of calories the resident consumed. The medical records documented through out that the resident had a very poor appetite and that the resident verbalized not being hungry and not wanting to eat. Documentation indicated the resident's spouse had come in for the evening meal most of the time. The spouse assisted the resident. The care plan documented that the resident was placed at an "assist" dining table on April 10, 2011.

Weekly weights were completed to monitor the resident and a supplement was added for extra calories. On some of the weekly weight documentation, the resident would actually gain a bit of

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weight only to lose it again the next week. It is not uncommon for individuals who have had fractures and surgery to lose weight. In addition, the medications the resident took could cause loss of appetite and even interfere with the taste of food. The facility was doing everything possible to encourage weight gain for the resident. Documentation indicated the identified resident's physician and family were being notified routinely of the weight loss.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The complainant stated that after the identified resident had supper, only one staff member transferred him from chair to bed and did not use a gait belt. The complainant did not know what the care plan directed or name of staff that transferred the resident.

FINDINGS:

The identified resident was no longer in the facility and a transfer could not be observed. However, transfers of other residents with the use of a gait belt were observed. The identified resident's care plan indicated the resident required assist of one staff for all ADL care. The care card used by the certified nurse aides (CNA's) to direct care, documented the resident required a one-person assist for transfers and use of a wheelchair for mobility. Neither care plan had a gait belt required for transfers. The Director of Nursing Services (DNS) was interviewed and said it was a facility's policy to use a gait belt for all transfers. She said that each new hire is provided a gait belt by the facility, which was considered part of their uniform. In addition, all new hires received this information upon orientation.

The resident was receiving training from physical therapy for strengthening and transferring skills.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The complainant stated that on the same visit (April 11 or 12, 2011,) the resident was coughing up an unusual amount of thick sputum. The complainant questioned the resident, who said the staff did a "swab." The complainant was not sure of the results and not sure if the resident was placed on antibiotics for this. The complainant suspected the resident had pneumonia.

FINDINGS:

The resident came to the facility with a diagnosis of a history of chronic bronchitis. The resident was receiving oxygen as ordered by the physician. The record had multiple entries in nursing notes about lung sounds checked on a regular basis by nursing staff from the time the resident arrived in the facility. He did sometimes cough. At times, he produced sputum and at times, he was noted to have a non-productive cough. Nursing notes dated April 11, 2011, documented hearing crackles and wheezes in the resident's lungs when checking lung sounds. The resident also had a non-productive cough at that time. The resident's physician was notified within minutes after the assessment. The facility received orders for antibiotic therapy for the resident for an upper respiratory infection. The resident's spouse was notified. Chest x-rays were also ordered and the results were provided to the physician on April 15, 2011. Although the x-rays showed findings consistent with pneumonia, the physician was treating the resident with antibiotics already and did not write an order to send the resident to the hospital. There was no documentation that a "swab" was done.

The surveyor checked the resident's flu and pneumonia vaccine status. The facility had offered both and the resident had declined; stating he did not know when but had already received the shots. The DNS produced a record from the resident's physician that indicated the resident was up to date on both vaccines.

The resident was discharged to the hospital on April 16, 2011 and was admitted with a diagnosis of pneumonia.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

The complainant stated that on Saturday, April 16, 2011, the resident had fell, was transported to the hospital and was still there. The complainant did not believe the identified resident had sustained any fractures, but was told by hospital's staff that the resident did have pneumonia. The complainant heard that possibly a family member was trying to assist the resident when he fell, but was not sure.

FINDINGS:

There was no evidence that the resident fell on April 16, 2011. The resident was transported to the hospital at the request of his spouse. The resident was admitted with pneumonia and did not have any fall-acquired fractures.

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CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #5:

The complainant stated they recently became a Durable Power Of Attorney (DPOA) for the identified resident on April 15, 2011. The complainant stated the identified resident's ex-spouse was also DPOA and was the responsible party for calls, not the complainant.

The complainant stated that they asked to see the resident's record prior to becoming the DPOA. The complainant stated this was done with permission from the resident. The administrator and a second unknown male refused to allow this, even when they were in the resident's room at the time. The complainant indicated he had not asked the facility's staff for results of the "swab" or if the identified resident was on an antibiotic. The complainant indicated some heated words were exchanged, and as the complainant left the building, a staff member "followed on my heels." The complainant planned to get the record on April 18, 2011.

The complainant called the Bureau of Facility Standards on April 21, 2011, at 9:15 a.m. to provide additional information. The complainant stated the person refusing access to the resident's record was identified as the administrator of the facility. The complainant was unable to get the name of the other man present when escorted out of the facility on April 18, 2011.

FINDINGS:

As the complainant stated, they were not the DPOA when the request was made prior to April 15, 2011. There was no documentation that the administrator and another male staff were in the room at that time. Because of the assessment and observations in the facility related to the identified resident's cognitive decline, the facility was obligated to protect the identified resident's privacy. The only person authorized to see the records at the time of the request was the resident's spouse.

A copy of the DPOA appointing a new agent was in the medical record. It was dated April 15, 2011. The administrator was interviewed and indicated that after this document was received the record would have been available for review by the agent. However, the facility had a protocol to follow before release of the record. The administrator indicated this seemed to aggravate the newly appointed DPOA. The DPOA left the facility without reviewing the record. The federal regulation (483.10(b)(2) documents that the facility has 24 hours (excluding weekends) to produce the clinical record upon written or oral request. The record can only be made available to the resident or a legal representative. With the advent of HIPPA (Health Insurance Portability and Accountability Act, 1996, P.O. 104-191), the facility and all health related facilities are

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under strict guidelines to protect the privacy of their consumers.

CONCLUSIONS:
Unsubstantiated.

As none of the complaint's allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

A handwritten signature in black ink that reads "LORENE KAYSER". The letters are somewhat stylized and connected, with a cursive-like flow.

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

LKK/dmj