



DEPARTMENT OF HEALTH & HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
Consortium For Quality Improvement and Survey & Certification Operations
Western Division of Survey & Certification

[Receipt of This Notice Is Presumed To Be May 11, 2012- Date Notice Faxed]

IMPORTANT NOTICE - PLEASE READ CAREFULLY

May 11, 2012

Kelly Spears, Administrator
Idaho Falls Care and Rehabilitation Center
3111 Channing Way
Idaho Falls, ID 83404

FILE COPY

CMS Certification Number: 13-5107

Dear Mr. Spears:

As you were previously informed, a recertification survey completed on January 26, 2012 by the Idaho Bureau of Facility Standards, Department of Health and Welfare (State Survey Agency) found that your facility, Idaho Falls Care and Rehabilitation Center (Idaho Falls), was not in substantial compliance with the applicable Federal requirements for nursing homes participating in the Medicare and/or Medicaid Programs under Titles XVIII and XIX of the Social Security Act. See 42 C.F.R. Part 483. The deficiencies documented during that survey were listed on a Form CMS-2567 (a copy of which you were previously provided) which indicated that the most serious deficiencies constituted actual harm to residents (**Scope/Severity = G**). A copy of which was sent to Idaho Falls, along with a letter dated February 14, 2012.

Accordingly, on March 21, 2012, the Centers for Medicare and Medicaid Services (CMS) notified you that certain remedies were being imposed against your facility. Specifically, we informed you that, as a result of the certification/finding of noncompliance based on our determination that your facility was not in substantial compliance with the participation requirements at 42 C.F.R. Part 483 as documented during the survey completed on January 26, 2012, and in light of the serious nature of the documented deficiencies (particularly the deficiencies posing actual harm to residents' health and safety), CMS determined, pursuant to 42 C.F.R. §§ 488.402(f)(4), 488.408 and 488.412(b), to terminate your facility's Medicare provider agreement at 12:01 a.m. on May 4, 2012. See 42 U.S.C. § 1395cc(b)(2); 42 C.F.R. §§ 488.456 and 489.53(a)(1) and (3). Notice of the proposed termination was published in the Post Register on April 19, 2012.

In addition, you were notified in the March 21, 2012 letter that a civil money penalty was being imposed, pursuant to 42 C.F.R. §488.430, in the total amount of \$10,000.00 for two instances of noncompliance. A denial of payment for new admissions was also imposed, effective April 5, 2012. You were advised that both remedies would remain in effect until this office either terminated your Medicare provider agreement, or determined that your facility had come into substantial compliance with the applicable Federal health and safety requirements.

Follow-Up Survey on May 3, 2012

Based on your representation that all previously documented deficiencies had been corrected, the State Survey Agency conducted a follow-up survey at your facility. This follow-up survey, which was completed on May 3, 2012, again documented that, notwithstanding your representation of compliance, Idaho Falls was not in substantial compliance with Federal requirements for nursing homes participating in the Medicare and/or Medicaid programs. See 42 C.F.R. Part 483. The May 3, 2012 survey findings are listed on a Statement of Deficiencies (Form CMS-2567) that is attached to this notice, the contents of which are incorporated herein by reference.

Certification of Noncompliance

Having reviewed the May 3, 2012 survey findings and the State Survey Agency's recommendations, this office concurs with the survey findings documented during the follow-up survey completed on May 3, 2012 (and listed on the above referenced CMS-2567L, the contents of which are incorporated herein by reference) that demonstrate that Idaho Falls failed to meet the following federal requirements and that the facility's failure constitutes substantial noncompliance:

- | | |
|-----------------------|---|
| 42 C.F.R. § 483.25(h) | (F323) Free of Accident Hazards/Supervision/Devices |
| 42 C.F.R. § 483.65 | (F441) Infection Control, Prevent Spread, Linens |

Accordingly, we have approved a certification/finding of noncompliance based upon our conclusion that Idaho Falls was not in substantial compliance with nursing home participation requirements at 42 C.F.R. Part 483.

On the basis of this certification/finding of noncompliance (i.e., the certification/finding of noncompliance relating to the survey completed on May 3, 2012), we have determined that the following remedy should continue in effect:

[X] Denial of payment for new admissions [42 C.F.R. § 488.417(a)]

This remedy was previously imposed, effective April 5, 2012 based on our certification/finding of noncompliance resulting from the survey completed on January 26, 2012. (See March 21, 2012 notice.) Accordingly, by this letter, you are hereby notified that, the denial of payment for new admissions that went into effect on April 5, 2012 (as noticed in our March 21, 2012 letter) continued in effect on (and subsequent to) May 3, 2012; and based on the certification/finding of noncompliance resulting from the survey completed on May 3, 2012, thereafter continued in effect on (and subsequent to) May 3, 2012. This remedy remained in effect until May 4, 2012 when this office terminated your Medicare provider agreement.

Termination of Medicare Provider Agreement

Effective 12:01 am on May 4, 2012, Idaho Falls Care & Rehabilitation Center's Medicare provider agreement was terminated. As stated above, Idaho Falls was not in substantial compliance with the Federal health and safety participation requirements applicable to Medicare-certified nursing homes, as documented during the surveys completed on January 26, 2012 and May 3, 2012.

Accordingly, as previously noticed in our March 21, 2012 letter, your facility's Medicare provider agreement was terminated at 12:01 a.m. on May 4, 2012. See 42 U.S.C. § 1395i(h)(2)(C); §1395cc(b)(2); 42 C.F.R. § 488.412(d); 42 C.F.R. §§ 488.456(b)(1) & 489.53(a)(1) and (3). Federal regulations required public legal notice of this decision. Such notice appeared in the Post Register on April 19, 2012.

Please be aware that the Medicare statute does not permit payments to be made to skilled nursing facilities whose provider agreements have been terminated. See 42 U.S.C. § 1395i(h)(2)(C); 42 U.S.C. § 1395cc(b)(2); 42 C.F.R. § 488.456(a)(1) & 489.53(a)(1) and (3). Therefore, as discussed in the next section, Medicare payments will continue on and after May 4, 2012 solely for the purpose of facilitating proper movement and placement of Medicare residents in your facility.

1. Payment for Medicare Residents

To facilitate the appropriate movement and placement of Medicare residents in your facility upon termination of your Medicare provider agreement, payments for those Medicare residents who were admitted to your facility prior to April 5, 2012 and who remained in your facility on May 4, 2012, may be permitted for up to a maximum of thirty (30) days after the effective date of termination. 42 C.F.R. § 489.55(a). Under 42 C.F.R. § 441.11, Medicaid payments may also continue for services rendered for up to a maximum of 30 days following the termination date. The State survey agency has agreed to make reasonable and timely efforts to assist in the transfer of Medicare and Medicaid eligible residents to other facilities or to alternate care. It is emphasized, however, that the exact period of payment (up to the maximum of thirty (30) days) will be determined based on the period of time that Idaho Falls is actively engaged in transferring Medicare and Medicaid eligible residents to other facilities or to alternate care as determined by this office. 42 C.F.R. § 489.55. Indeed, given the circumstances of this case, this office will be working with the State Agency to expeditiously relocate residents in the shortest possible time period.

We have coordinated this action with the State Medicaid Agency which will take concurrent action under Title XIX of the Social Security Act.

2. Application for Readmission Following Involuntary Termination

Under the regulations at 42 C.F.R. § 489.57(a), when a provider agreement is terminated by CMS, a new agreement will not be accepted until it has been determined that the reason for the termination of the agreement has been removed and there is a reasonable assurance that it will not recur. **Once terminated, therefore, you must demonstrate through a reasonable assurance period that you can maintain substantial compliance for at least one hundred eighty (180) consecutive days.** Compliance with the applicable participation requirements at 42 C.F.R. Part 483 will be verified by surveys conducted at the beginning and end of this period. During this period, any finding of noncompliance will result in a finding that reasonable assurance has not been demonstrated. Additionally, before readmission to the Medicare program, you must demonstrate your ability to comply with all pertinent requirements of Title XVIII of the Social Security Act (including your financial ability to provide the services required for Medicare participation). See, e.g., 42 C.F.R. § 489.12(a)(4); See generally 42 C.F.R. Part 489, Subpart B.

You must also establish that you have fulfilled, or have made satisfactory arrangements to fulfill, all of the statutory and regulatory responsibilities of your previous provider agreement (including resolution of all outstanding financial obligations due the Medicare program). 42 C.F.R. § 489.57(b). Assuming substantial compliance with participation requirements is documented at the beginning and end of the reasonable assurance period, and assuming all other federal requirements are met, Medicare certification and reimbursement will begin following the conclusion of the reasonable assurance period in accordance with the terms of 42 C.F.R. § 489.13.

Additional Documentation Supporting Certification/Finding of Noncompliance

We emphasize that even though the certification/finding of noncompliance (and thus the enforcement actions noticed in this letter) are based on the findings of the May 3, 2012, survey as set forth in the Form CMS-2567L referenced herein, CMS may have additional evidence and information (including, but not limited to State licensure information, correspondence, provider records, or verified complaints) relating to the deficiencies identified during the May 3, 2012, surveys that may be presented at the time of (or before) an administrative hearing challenging CMS's certifications/findings of noncompliance. This corroborating evidence/information may be used at a hearing to resolve possible conflicts of factual information and to otherwise support CMS's adverse findings. Accordingly, nothing in this notice should be viewed as limiting or constraining CMS's right to present this additional evidence/information at an administrative hearing. (See State Operations Manual § 3026F.)

Appeal Rights

If you disagree with our certification/finding of noncompliance that is based upon our determination that Idaho Falls Care and Rehabilitation Center was not in substantial compliance with controlling Medicare participation requirements at 42 C.F.R. Part 483 as documented during the survey completed on May 3, 2012, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services' Departmental Appeals Board. Procedures governing this process are set out in 42 C.F.R. § 498.40, et seq. A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to:

Chief, Civil Remedies Division
Departmental Appeals Board MS 6132
Cohen Building, Room 637-D
330 Independence Avenue, SW
Washington, D.C. 20201

Please also send a copy to: Chief Counsel
Office of General Counsel, DHHS
2201 Sixth Avenue, M/S RX-10
Seattle, WA 98121-2500

A request for a hearing must contain the information specified in 42 C.F.R. § 498.40(b) and must identify the specific issues, the findings of fact and the conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You may be represented by counsel at a hearing at your own expense.

Please note that the above-mentioned right to request an administrative hearing is separate and distinct from your right to request a hearing to challenge the certification/finding of noncompliance based on the results of the January 26, 2012 survey as set forth in CMS' notice of March 21, 2012.

Filing of Medicare or Medicaid Claims

Please note that any filing of Medicare or Medicaid claims for new admissions during the period that a denial of payment for new admissions (DPNA) is in effect could result in such claims being considered "false" claims under applicable federal statutes and thus potentially subjecting the filing entity to a referral to the appropriate authorities and possibly to the penalties prescribed under such statutes. An exception possibly applies where a timely appeal of the controlling certification/finding of noncompliance is filed (and remains pending) under 42 C.F.R. Part 498, and where your facility has made arrangements acceptable to your Medicare and Medicaid fiscal intermediaries to submit the claim (or claims) with prominent flagging clearly indicating that the claim(s) is/are being filed not for current payment, but "under protest" and for the sole purpose of preserving a timely filing should the facility prevail on its administrative appeal under 42 C.F.R. Part 498.

We have coordinated this action with the State Medicaid Agency which will take concurrent action under Title XIX of the Social Security Act.

If you have further questions, please contact CAPT Jerilyn McClain or CAPT Dorothy Stephens of my staff at (206) 615-2313.

Sincerely,

Jerilyn McClain, SCE Branch Manager

for Steven D. Chickering
Associate Regional Administrator
Western Division of Survey and Certification

Enclosures: Statement of Deficiencies (CMS 2567L)
CMS 2567B

cc: Debby Ransom, Idaho Bureau of Facility Standards
Idaho State Ombudsman
Idaho Department of Justice
Office of General Counsel, DHHS
State Medicaid Agency

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

PRINTED: 05/24/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135107	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 05/03/2012
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NAME OF PROVIDER OR SUPPLIER IDAHO FALLS CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3111 CHANNING WAY IDAHO FALLS, ID 83404
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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{F 000}	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Standard Abbreviated, follow-up and complaint survey conducted May 1-3, 2012 onsite at Idaho Care and Rehabilitation Center located in Idaho Falls, Idaho. A sample of 14 residents from a census of 56 included 11 current residents and 3 discharged residents.</p> <p>The surveyors conducting the survey were: Lea Stoltz, QMRP, Team Coordinator Barbara Daggy, BSN, RN Lynda Evenson, BSN, RN</p> <p>Survey Definitions: ADON = Assistant Director of Nursing BFS = Bureau of Facility Standards BIMS = Brief Interview for Mental Status CNA = Certified Nurse Aide DNS = Director of Nursing Services I/A = Incident & Accident IAIS = Incident & Accident Summary IDT = Interdisciplinary Team LN = Licensed Nurse LPN = Licensed Practical Nurse MAR = Medication Administration Record MDS = Minimum Data Set POC = Plan of Correction RD = Registered Dietician RN = Registered Nurse SDC = Staff Development Coordinator</p>	{F 000}		
{F 323} SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives</p>	{F 323}		

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

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{F 323}	<p>Continued From page 1</p> <p>adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and review of facility Incident & Accident reports the facility failed to implement physician ordered and care planned interventions for fall prevention for 1 of 4 sampled Residents (#17). This failure had the potential to place residents at risk for falls and injury related to falls.</p> <p>Findings include:</p> <p>1. Resident #17 admitted to the facility on 1/26/12 and readmitted on 4/12/12 with diagnoses that included history of falls and Alzheimer ' s disease. The admission MDS (a comprehensive assessment) indicated Resident#17 was severely impaired in decision making and had disorganized thinking. The resident required extensive assistance of 2 or more persons for bed mobility, transfers, and toilet use. The admission nursing assessment showed the resident required ¼ side rails on the bed and an alarm on the bed and chair.</p> <p>The April 2012 physician orders included an order dated 4/12/12 for pressure alarm in bed due to history of falls and included staff instruction to check alarm placement and battery function every shift, every day.</p> <p>A facility form titled "Device Evaluation" dated</p>	{F 323}		

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{F 323}	<p>Continued From page 2</p> <p>2/6/12 and updated on 4/12/12 indicated the pressure alarm to the bed was to remain part of the care plan. The care plan identified Resident #17 at risk for falls on 2/13/12 and on 4/12/12, with notation to continue the plan of care. Care plan entries noted fall prevention measures for pressure alarm to bed, began 2/16/12, and were discontinued on 4/24/12. Bolster sheet (creates raised mattress border) to mattress to define edges of bed, and a non skid floor mat to bedside were implemented on 4/23/12. The facility initiated 1:2 supervision while in the resident room and 1:1 while out of the room on 4/23/12.</p> <p>a) An I/A report dated 4/13/12 at 3:00pm indicated Resident #17 had a fall. The resident was found on the floor next to her bed. She stated that she rolled out of bed. The I/A recorded no witnesses and indicated the alarm was in place and the battery was in working order, but the alarm was turned off and did not sound. The facility initiated non skid mats to the floor at bedside and recommended bolsters to the mattress to prevent further falls.</p> <p>The I/A indicated the root cause conclusion was "resident just rolled off the bed." The root cause analysis did not examine why or what caused the resident to roll out of bed. The I/A investigation documentation showed no evidence staff attempted to ask the resident what she was trying to do when she rolled out of bed such as go to the bathroom, get a drink, change positions, or reach personal items.</p> <p>An I/A Investigation Summary (IAIS) and IDT Review form dated 4/16/12 referenced Resident 17's 4/13/12 fall. It provided no additional</p>	{F 323}		

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{F 323}	<p>Continued From page 3</p> <p>information and concluded the probable root cause was 'Resident rolled off bed.' The form was signed by the Administrator, DNS, ADON, Social Services, Therapy, Housekeeping, CCM [Abbreviation unknown], Activities, Nurse Manager, SDC, and Dietary Manager.</p> <p>Nursing notes dated 4/13/12 indicated the resident was not injured, the facility monitored the resident and put new interventions of fall mat at bedside and a perimeter mattress (same as bolsters) in place.</p> <p>Review of the I/A, the IAIS, and the IDT Review form revealed no acknowledgment that Resident #17's care planned intervention for falls was not followed. The pressure alarm on the bed was not turned on but there was no evidence the facility evaluated why the alarm was turned off or whether other alarms in the facility were also turned off. The facility investigation included only a checklist type of form and did not include interviews with staff regarding the alarm at the time of the fall and no evidence of evaluation to determine continued need for the alarm or need for staff education about alarms. The investigation for the fall of 4/13/12 did not include staff investigation sheets which were noted to be included with other I/A reports.</p> <p>b) An I/A report dated 4/23/12 at 3:00 pm indicated Resident #17 had another fall. A CNA was passing by the resident room and noticed Resident #17 sitting on the floor mat next to the bed. The resident was not able to describe how she ended up on the floor.</p> <p>The I/A again indicated the alarm was in place</p>	{F 323}			

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{F 323}	<p>Continued From page 4</p> <p>but the alarm was turned off and did not sound. The I/A did not indicate whether the bolsters were on the bed. The facility immediately initiated increased supervision of 1:1 with recommendations to prevent further falls; 1:1 supervision while out of room and 1:2 supervision while in room.</p> <p>The facility concluded the root cause for the fall was "resident is confused and has poor safety awareness."</p> <p>The IAIS dated 4/24/12 confirmed the probable root cause was poor safety awareness, and the new intervention put in place was the increased supervision. The documentation did not show evidence the facility investigated why the alarm was turned off, who turned it off, and other factors about Resident #17's alarm.</p> <p>A facility form titled "Event Investigation Interview Record" dated 4/24/12 at 6:00pm, accompanied the 4/23/12 I/A and documented an interview with LN #1. NOTE: The interview documented information related to the fall of 4/13/12 and was conducted 11 days after the fall. The interview record indicated LN #1 reported a CNA working in another room heard Resident #17 yelling in her room. The CNA called the nurse station on her cell phone. LN #1 entered the room and found Resident #17 on the floor. The resident was incontinent. The resident stated she rolled out of bed. The report indicated the bed alarm was not sounding and was in the "off" position, but was on in the morning.</p> <p>Two Staff Investigation Sheet forms were also attached to the 4/23/12 I/A. CNA #2 and CNA #3</p>	{F 323}		

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{F 323}	<p>Continued From page 5</p> <p>both indicated the alarms were in place, the alarms were not working, the alarms were not checked at the start of the shift, and the alarms did not sound.</p> <p>Nursing notes dated 4/23/12 at 3:00pm indicated Resident #17 would be moved to a different room to facilitate 1:2 supervision while in the room and 1:1 supervision while out of the room.</p> <p>On 5/2/12 at 12:40 pm and 3:00 pm, the DNS was interviewed regarding Resident #17's falls on 4/13/12 and 4/23/12 in regard to the pressure alarm on the bed.</p> <p>The DNS stated regarding the 4/13/12 fall; "When I went down there & she [Resident #17] was on the floor, the nurse told me the alarm wasn't working. I didn't actually look at the alarm. The aide and the nurse said it [alarm] wasn't working." The DNS stated she knew the alarm was not working, but did not know the alarm was turned off. She said the CNA thought the alarm malfunctioned. The DNS did not remember if the same alarm was put back on the resident's bed.</p> <p>When the DNS was asked if any staff were interviewed about the alarm being turned off. She stated, "No." She was asked if any inservices were provided regarding turning alarms off and on. She stated, "No." When asked about the I/A and the investigation done by the IDT team and the lack of investigation regarding the alarm, she stated the investigation focused more on "why did she roll out of bed instead of the alarm." At the time of the fall on 4/13/12, the DNS said the resident still had the alarm ordered by the</p>	{F 323}		

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{F 323}	<p>Continued From page 6</p> <p>physician and was care planned to have the pressure alarm on the bed.</p> <p>When asked if staff checked alarms, the DNS said the alarms were to be checked on rounds. She said, "Staff are looking to see that it is in place - the alarm and pad." She further stated, "They [staff] should, but I do not know if they check to be sure the alarm is on."</p> <p>The DNS stated that it was not until Resident #17's second fall on 4/23/12 that staff realized there were 2 different types of alarms in the facility. The DNS said that last week on either the 23rd or 24th [of April] was when the facility identified there were 2 types of alarms used for residents. The DNS showed the survey team 2 types of alarms: the Economy Alert alarm which had an off/on switch on the bottom of the unit and a Deluxe Pad Alert alarm which had a button on the back of the unit. The DNS stated the Economy Alert alarm had to be turned off or on using the switch at the bottom of the unit. The Economy had to be turned back on to function. The DNS explained that the Deluxe Pad Alert alarm could be silenced by using the button on the back of the unit. The Deluxe alarm had no on/off switch and switched back on automatically when the resident was placed on the pad. She stated the Economy Alarm was used on Resident #17's pressure pad on the bed. She stated the facility usually used the Deluxe Pad Alert alarm and not the Economy Alarm.</p> <p>The DNS stated, "Everyone I talked to did not know there were 2 different alarms." When asked who she interviewed, the DNS said she</p>	{F 323}		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135107	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 05/03/2012
NAME OF PROVIDER OR SUPPLIER IDAHO FALLS CARE & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3111 CHANNING WAY IDAHO FALLS, ID 83404		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 323}	<p>Continued From page 7</p> <p>interviewed the Plant Operations Manager and other managers. When asked if she interviewed nurses, she said she interviewed LN #1 and LN #4 and they did not know there were 2 different types of alarms. The DNS said she did not interview any CNAs about alarms.</p> <p>The DNS said when the facility discovered the two types of alarms on 4/23/12 or 4/24/12, the Plant Operations Manager "did a sweep of the building" and removed about 4 of the Economy Alert alarms. She stated, "I don't have any idea how long they have been here or when they came in."</p> <p>The DNS stated as soon as the 2 different alarms were discovered, the facility conducted in-service education. The DNS gave the survey team In-service Training Record forms which included the following, in part:</p> <ul style="list-style-type: none"> * Date of training: 4/24/12, 4/25/12, 4/26/12, 5/1/12 * Course Name: "Overview of POC...including differentiating between types of alarms * The form included signatures of 40 staff members including CNAs, LNs, Dietary, Housekeeping, Activities, Human Resources. * ...F323 - Residents will be free of accident hazards by use of supervision/safety devices including differences in safety alarms used <p>Historical Information: An I/A, dated 3/15/12 at 8:30 am, documented Resident #22 had a fall. Resident #22's I/A documented, in part:</p> <ul style="list-style-type: none"> * "...Event: Fall * ...Describe the circumstances of the event and what actions, if any, have been taken currently: "Pt [patient] found in sitting position next to her bed and w/c [wheelchair]...Alarms in place but not 	{F 323}		

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{F 323}	<p>Continued From page 8</p> <p>sounding. Intervention is Alarm box changed to a non-switch off box..."</p> <p>* ...Was an alarm being used for resident? 'Yes' [checked]</p> <p>* Was alarm in place? 'Yes' [checked]</p> <p>* Alarm turned on? 'No' [checked]</p> <p>* Did the alarm sound? 'No' [checked]</p> <p>* Was the alarm battery in working order? 'Yes' [checked]</p> <p>* Interventions initiated immediately after fall: "changed out alarm box to self turn on..."</p> <p>* Recommendations to prevent further falls: "changed out alarm box to self turn on..."</p> <p>During the review of I/A fall records, it was noted Resident #22 was found in a sitting position next to her bed and wheelchair, the alarms were in place, but the alarm was turned off and not sounding. The facility immediately " changed the alarm box to self turn on ... " The I/A indicated recommendations to prevent further falls " changed out alarm box to self turn on ... "</p> <p>Review found no documentation that the IDT or RN Consultant, who completed part of the I/A, followed-up with facility staff, the DNS, or the Administrator regarding the 2 different alarms mentioned in the I/A: the "switch off" alarm and the "self turn on" alarm.</p> <p>NOTE: From the interview with the DNS above, the alarm with the "switch off " alarm matched the description of the Economy Alert Alarm and the "self turn on" alarm matched the description of the Deluxe Pad Alert alarm indicating the facility knew on 3/15/12 that 2 different types of alarms existed in the facility.</p>	{F 323}		

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{F 323}	Continued From page 9 The facility knew there were 2 different alarms present in the facility when Resident #22 fell on 3/15/22 and staff recognized the "self turn on" alarm was more appropriate for Resident #22 than the alarm with the "switch off." The presence of two types of alarms in the facility was not evaluated when it was discovered Resident #22's alarm was turned off on 3/15/12 and subsequently, Resident #17 fell two times in April 2012 with the same type of alarm turned off.	{F 323}		
{F 441} SS=E	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.	{F 441}		

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{F 441}	<p>Continued From page 10</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and review of facility policies, the facility failed to maintain an infection control program under which the facility implemented measures to control and prevent infections in the facility.</p> <p>A. The facility evidenced confusion and inconsistency regarding infection control requirements for (Resident #16), 1 of 2 residents known to have active infection with a contagious disease-producing organism.</p> <p>B. The facility failed to ensure staff washed hands before and after each direct resident contact for which handwashing was indicated by professional standards.</p> <p>C. The facility failed to ensure infection control measures to prevent spread of infection by contaminated environmental surfaces.</p> <p>These failures involved 3 licensed nurses, 6 nursing assistants, and directly affected Resident #s 3, 16, & 17, who resided on the 100 and 400 halls. This placed other residents residing on those halls at risk for infection to be spread from one resident to another.</p>	{F 441}		
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{F 441}	<p>Continued From page 11</p> <p>Findings include: 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>Regarding C difficile infection, the CDC noted that C difficile is passed through feces and can be spread to food, surfaces, and objects when hands are not thoroughly washed. C difficile can remain active for weeks or months at a time and can spread quickly. The CDC wrote: Transfer of pathogen (C difficile) to the patient via the hands of health-care workers is thought to be the most likely mechanism of exposure. Handwashing remains the most effective means of reducing hand contamination, and proper use of gloves is a measure that further helps to minimize transfer of the pathogen from one surface to another.</p> <p>The CDC recommended:</p> <ul style="list-style-type: none"> · Isolate the resident immediately · Wear gloves and gowns for direct care · Dedicate or perform cleaning of any shared equipment 	{F 441}		

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{F 441}	<p>Continued From page 12</p> <ul style="list-style-type: none"> Clean surfaces with bleach and ensure adequate cleaning and disinfection of environmental surfaces especially items likely to be contaminated with feces and surfaces that are touched frequently <p>Review of the facility infection control plan and training materials showed the facility expectations were consistent with the CDC guidelines. In addition, the facility documents directed staff to remove gloves before touching non-contaminated items and environmental surfaces.</p> <p>A. Isolation: Contact Precautions The facility provided "Precaution Cards" to direct staff regarding necessary measures for each type of isolation. The Contact Precautions card read in part "read the precaution card to identify which precautions you need to take and make sure you take those precautions" and included, but was not limited to:</p> <ul style="list-style-type: none"> After washing hands, do not touch potentially contaminated surfaces or items in the room Wear gloves when entering the room Wear gloves when providing care for the resident Remove gloves when leaving the room Wash hands immediately after removing gloves <p>Record review showed Resident #16 admitted to the facility on 5/6/11 with four subsequent discharges to the hospital and readmissions to the facility. The current care plan indicated the facility initiated "contact isolation per facility protocol" on 9/27/11 related to a C difficile infection. A gastroenterology consult, dated 4/4/12, indicated Resident #16 still had C difficile</p>	{F 441}		
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{F 441}	<p>Continued From page 13</p> <p>infection and the physician ordered a new two-month course of a strong antibiotic, specific to the treatment of C- difficile. According to a progress note, dated 4/5/12, the attending medical provider concurred and directed the facility to continue the contact precautions for C difficile.</p> <p>During the initial tour on 5/1/12 at 1:40 pm, a sign was posted in the door to Resident#16's room. The sign cautioned visitors to check with the nurse before entering the room. When the surveyor asked about the sign, LN #10 said Resident #16 was in isolation for a C difficile infection. LN #10 said the surveyor must wear a gown, gloves, and a hair cover (since the surveyor had long hair) to enter the room.</p> <p>After donning the protective gear as directed; the surveyor entered the room at 1:43 pm and greeted Resident #16. At 1:45 pm, CNA #7 entered Resident #16's room; he wore no protective equipment/garments and did not wash his hands upon entering the room. CNA #7 touched the resident and her chair and leaned over the resident to examine the oxygen tank. When finished, CNA #7 left the resident room without washing his hands.</p> <p>Observation on 5/2/12 at 10:15 am revealed Resident #16 requested to leave the sports lounge. CNA #9 wheeled the resident to her room (Resident #16's room). CNA #9 wore no gloves and did not wash her hands as she entered the room. CNA #9 transferred the oxygen tubing from the portable cannister to the oxygen concentrator.</p> <p>CNA #8 entered the room and used alcohol gel</p>	{F 441}		
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{F 441}	<p>Continued From page 14</p> <p>but did not wash hands or wear gloves. Both CNAs adjusted covers and placed the call light in the resident's hand. Resident #16 complained that she was cold and CNA#8 re-connected the oxygen tank and wheeled the resident into the hall without washing hands. In the hallway, CNA #8 stopped and reached under Resident #16's legs and bottom to adjust the cover. CNA #11 stopped and helped adjust blankets, he then used alcohol based hand rub but did not wash hands.</p> <p>As CNA #8 wheeled the resident down the hall, LN #6 approached and directed CNA #8 to return Resident #16 to her room so the LN could take vital signs. LN #6 entered Resident #16's room without washing her hands. She carried a blood pressure cuff, stethoscope, ear thermometer, and the oxygen saturation measuring device (vital sign tools). All were communal tools obtained from the medication cart. LN #6 put the vital sign tools on the resident's overbed table which was directly in front of the resident, was frequently touched and was considered a contaminated environmental surface. The LN did not place a barrier on the table. LN #6 wore no gloves while she took the blood pressure. LN #6 used a wipe on the finger probe and then checked the oxygen level, but did not clean the device after use. LN #6 took the temperature in the ear and placed the stethoscope under the resident's clothing to listen to her lungs and heart. LN #6 wiped the membrane of the stethoscope, but not the bell or tubing and the stethoscope hung around her neck. LN #6 placed the vital sign tools on the sink which is considered a contaminated environmental surface. LN #6 washed her hands, but returned to the resident, placed the tools again on the contaminated table, took the call</p>	{F 441}		
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{F 441}	<p>Continued From page 15</p> <p>light from the resident's hand and clipped it to the mattress which had no linen.</p> <p>LN #6 pushed the resident's wheelchair and did not wash her hands when she left Resident #16's room. LN #6 placed the vital sign tools on the medication cart as she passed by. The vital sign tools were contaminated and the nurse did not clean them before leaving the isolation room. LN #6 pushed Resident #16's wheelchair into the sports lounge and then went directly to the nurse station, got a chart from the rack, and sat down to chart without washing or sanitizing her hands.</p> <p>B. Care Observation and handwashing</p> <p>1) On 5/1/12 at 4:55 pm, CNA #12 and #13 were observed providing incontinent care to Resident #3. The CNAs washed their hands and put on gloves when they entered the room. They removed the resident's pants and incontinent briefs. The front of the briefs were observed with a gray-brown stain. CNA #12 stated the stain could be caused by vaginal discharge and a bowel movement. After the brief was removed and before the resident was cleaned, the resident's buttocks were laid directly on the mattress cover. (See Environmental Surfaces described below).</p> <p>CNA #12 and #13 washed the resident's perineal area. CNA #13 placed the soiled briefs in a plastic bag, removed her gloves and, without washing her hands, left the room with the plastic bag, opening the door with her unwashed hand. CNA #13 re-entered the room, washed her hands and regloved. CNA #12 removed her gloves, washed her hands and regloved.</p>	{F 441}		

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{F 441}	<p>Continued From page 16</p> <p>CNA #12 applied cream to the right buttocks area and then handed the partially used packet of cream to CNA#13. CNA #13 took the partially used packet and applied the cream but needed more. CNA #12 reached into her pocket with a soiled gloved hand and removed packets of cream which she handed to CNA #13. CNA #13 placed some of the packets on the resident's soiled overbed table, opened one of the packets, and applied the cream to the resident's buttocks and perineal area. The CNAs replaced the resident's incontinent brief.</p> <p>CNA #13 removed her gloves and, without washing her hands, placed the unused packets of cream in her pocket, adjusted the resident's blankets, placed the urinary collection bag on the side of the bed and picked up Resident #3's head phones, placed them on her own ears first, and then placed them on the resident's ears. CNA #13, only then, washed her hands before leaving the room.</p> <p>After CNA #12 finished replacing Resident #3's brief, she removed her gloves, and without washing her hands, left the room with a garbage bag. CNA #12 re-entered the room, touched her gait belt, which was fixed around her waist, and then washed her hands before leaving the resident's room</p> <p>2) On 5/2/12 at 1:35 pm, LN #14 was observed changing a dressing to Resident #17's coccyx</p>	{F 441}		

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{F 441}	<p>Continued From page 17</p> <p>ulcer. LN #14 washed her hands, donned gloves, removed the old dressing and placed it in a plastic bag. The LN did not remove her gloves or wash her hands before she wiped the ulcer with clean saline gauze. She placed the gauze in the plastic bag after it was used. LN #14 replaced the dressing, removed her gloves, and without washing her hands, reached in her pocket for a pen, dated the new dressing, put the pen back into her pocket, picked up the plastic bag containing the soiled dressing and saline gauze, placed the plastic bag directly on the sink area (considered an environmental surface), washed her hands, picked up the plastic bag and left the room. The sink area where the plastic bag was placed was not disinfected after the bag was removed from the room.</p> <p>C. Environmental surfaces</p> <p>During the initial tour on 5/1/12 at 1:12 pm observation found the mattress in Resident #3's room had no linens. The mattress was a special air mattress with a cover that served as the bottom sheet. The mattress cover was grossly soiled with four distinct rings that were brownish white and gray in color. The mattress had a strong foul odor that permeated the room. The resident was not in the bed. At least two staff entered the room to care for the roommate during the observation. On 5/1/12 at 4:00 pm, the mattress and room still had the strong odor and Resident #3 lay in bed.</p> <p>On 5/1/12 at 4:55 pm, CNA #13 and CNA #12 provided incontinent care to Resident #3. Resident #3 was in bed on the soiled mattress, the odor was still present. When CNA #12</p>	{F 441}		

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{F 441}	<p>Continued From page 18</p> <p>removed the brief, a thick substance that was gray and brown in color was present. CNA #12 said the substance was vaginal discharge and bowel movement. The substance in the brief had similar color to the stain on the mattress. CNA #s 12 & 13 completed care and the resident remained on the soiled and odorous mattress.</p> <p>Upon completion of care, CNA #13 hung the urinary collection bag on the side of the bed. The bed was low and the bag sat directly on the floor. The floor is considered to be a highly contaminated environmental surface and the tubing that drains the collection bag was in contact with the floor which created a potential route for bacteria to enter the urine bag and potentially the resident's bladder where it may cause infection.</p> <p>In an interview on 5/2/12 at 4:45 pm, the Housekeeping Manager said he changed Resident #3's mattress last night. He said he was called to the room to clean a spill. He noted the overbed table was dirty, so he leaned over to clean the table and he got a whiff of a bad odor. The Housekeeping Manager said he has been doing this a long time and it smelled like "down there" indicating the private area. He said he called the staff and had them get the resident out of bed and he changed the mattress cover. The Housekeeping Manager said when they [residents] lay in one spot it gets a lighter color and then you know it is dirty.</p> <p>In an interview on 5/2/12 at 3:27 pm, the DNS said the facility changed the special mattress covers weekly on the resident's bath day. Resident #3's bath day was Friday 4/27/12. The</p>	{F 441}		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/24/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135107	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 05/03/2012	
NAME OF PROVIDER OR SUPPLIER IDAHO FALLS CARE & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3111 CHANNING WAY IDAHO FALLS, ID 83404		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 441}	<p>Continued From page 19</p> <p>DNS said any time the mattress gets soiled the staff were expected to request housekeeping to change them. The DNS said the facility has extra mattress covers on hand in the facility.</p> <p>In an interview on 5/2/12 at 3:27 pm, surveyors discussed observations of infection control failures with the facility infection control nurse LN #5. LN #5 said staff must wash hands when entering a resident room to prevent contamination from one resident to another and must wash hands immediately whenever gloves were removed and wash hands again before leaving the resident room.</p> <p>LN #5 said Resident #16 was on contact precautions because of C difficile. LN #5 said bacteria were carried in the stool and a primary symptom was diarrhea. LN #5 said the facility automatically instituted contact precautions (isolation) for C difficile diagnosis. LN #5 said the facility expectation was for staff to wash hands and put on a gown and gloves to perform incontinent care and personal care that may result in contact with stool. LN #5 said LN #10 gave inaccurate direction to the surveyor. LN #5 said when staff goes into the room just to answer the call light or speak with the resident; they do not need to wear a gown. LN #5 said everyone must wash their hands when entering and before leaving the room.</p> <p>When asked about reusable equipment such as blood pressure cuffs, thermometers, stethoscopes, and oxygen measuring devices, LN #5 said the only thing specific to kill C difficile was 1:10 bleach solution or bleach wipes. LN #5 said anything that came into contact with the resident</p>	{F 441}		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135107	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 05/03/2012
NAME OF PROVIDER OR SUPPLIER IDAHO FALLS CARE & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3111 CHANNING WAY IDAHO FALLS, ID 83404		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 441}	<p>Continued From page 20</p> <p>must be cleaned. LN #5 said staff must use bleach wipes to clean all surfaces of the device before it is used on another resident. LN #5 said the facility provided small individually packaged wipes and larger wipes in a dispenser on the medication and treatment carts. LN #5 stated that the nurse had bleach wipes on her cart and she should have taken the wipes into the room and cleaned the equipment before it left the isolation room.</p> <p>LN #5 said Resident #16 was placed on contact isolation precautions in September 2011 and has been on isolation precautions continuously since. LN #5 said Resident #16 had not been symptom free for any 7-10 day period which indicated active infection persisted. LN#5 said the resident would be OK for awhile and then the diarrhea would start again. LN #5 acknowledged that the staff did not follow accepted standards of practice regarding handwashing and cleaning of communal resident care equipment. LN #5 acknowledged that residents should not be placed in a bed soiled with body fluids and that urine collection bags should not come in contact with the floor. LN #5 stated that the facility provided education in infection control and she said she could not explain why staff did not follow accepted infection control practices.</p>	{F 441}		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001300	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 05/03/2012
NAME OF PROVIDER OR SUPPLIER IDAHO FALLS CARE & REHABILITATION CEN'		STREET ADDRESS, CITY, STATE, ZIP CODE 3111 CHANNING WAY IDAHO FALLS, ID 83404		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{C 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 follow-up and complaint survey of your facility. The surveyors conducting the survey were: Lea Stoltz, QMRP, Team Coordinator Barbara Daggy, BSN, RN Lynda Evenson, BSN, RN	{C 000}		
{C 671}	02.150.03,b b. Proper handling of dressings, linens and food, etc., by staff. This Rule is not met as evidenced by: Please refer to F441 as it refers to infection control practices.	{C 671}		
{C 790}	02.200.03,b,vi vi. Protection from accident or injury; This Rule is not met as evidenced by: Please refer to F323 as it relates to falls.	{C 790}		

Bureau of Facility Standards

TITLE

(X8) DATE

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



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 30, 2012

Kelly Spiers, Administrator
Idaho Falls Care & Rehabilitation Center
3111 Channing Way
Idaho Falls, ID 83404

Provider #: 135107

Dear Mr. Spiers:

On **May 3, 2012**, a Complaint Investigation survey was conducted at Idaho Falls Care & Rehabilitation Center. Lea Stoltz, Q.M.R.P., Lynda Evenson, R.N. and Barbara Daggy, R.N. conducted the complaint investigation. The complaint survey was completed in conjunction with a follow-up to a Recertification, Complaint Investigation & State Licensure survey.

The following documentation was reviewed:

- * Resident Council meeting minutes from January 2012 to May 2012;
- * Grievances from January 2012 to May 2012; and
- * Abuse Investigations from January 2012 to May 2012.

Interviews were conducted with the facility's administrator, Registered Nurse Clinical Consultant, Director of Nursing Services, Social Services Director and the Regional Vice-President.

A Resident Group meeting attended by nine residents was conducted.

The local ombudsman was contacted. She had no concerns identified to her regarding verbal abuse of residents by the Administrator.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00005508

Kelly Spiers, Administrator
May 30, 2012
Page 2 of 2

ALLEGATION #1:

The complainant stated the new administrator was unprofessional, verbally abusive and disrespectful to residents. The complainant stated the administrator told an unidentified resident she did not know how to read because she was from an identified small town. The complainant stated the resident was upset and went to her room crying and yelling. The complainant stated a corporate person, whose office was in the facility, was told of the administrator's behavior.

FINDINGS:

An interview was conducted with corporate staff who were in the building, including the Regional Vice-President and Registered Nurse Clinical Consultant, and facility staff including the Social Services Director and Director of Nursing Services. The corporate and facility staff had no reports of any kind concerning inappropriate behavior by the administrator.

The Regional Vice-President stated the facility had a Hotline that could take anonymous calls from residents, families and staff. He said there were no reports concerning the administrator from the facility's Hotline.

At the Group Meeting, residents were asked if staff were respectful to them. The residents stated staff was respectful. Residents were asked if new staff were respectful. Residents replied that the new staff was "working out OK."

CONCLUSIONS:

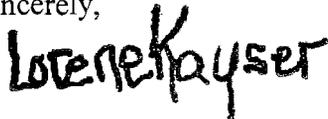
Unsubstantiated. Lack of sufficient evidence.

The complainant also stated the Administrator told a staff member he was only employed by the facility because he was a pretty boy, not because he was smart.

Because this issue is not regulatory, the survey team did not investigate the allegation.

Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,



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

LKK/dmj



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
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Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

May 30, 2012

Kelly Spiers, Administrator
Idaho Falls Care & Rehabilitation Center
3111 Channing Way
Idaho Falls, ID 83404

Provider #: 135107

Dear Mr. Spiers:

On **May 3, 2012**, a Complaint Investigation survey was conducted at Idaho Falls Care & Rehabilitation Center. Lea Stoltz, Q.M.R.P., Lynda Evenson, R.N. and Barbara Daggy, R.N. conducted the complaint investigation. This complaint investigation was completed in conjunction with a follow-up to a Recertification, Complaint Investigation and State Licensure survey, which was conducted on January 26, 2012.

A tour was conducted immediately upon entering the facility and included observations of dining; grooming; residents' rooms, bathrooms and commodes for odors and cleanliness and fall precautions, such as alarms. Staff was observed performing incontinent care for residents at which time bedding was evaluated for odors and cleanliness.

The following documentation was reviewed:

- * Resident Council meeting minutes from January 2012 to May 2012;
- * Grievances from January 2012 to May 2012;
- * Abuse Investigations from January 2012 to May 2012; and
- * Closed record of the resident identified in the complaint.

Interviews were conducted with the facility's administrator, Registered Nurse Clinical Consultant, Director of Nursing Services, Social Services Director, Infection Control Nurse, Housekeeping Manager and the Regional Vice-President.

Kelly Spiers, Administrator
May 30, 2012
Page 2 of 5

A Resident Group meeting attended by nine residents was conducted and included discussions regarding dining, linen changes and room odors.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00005435

ALLEGATION #1:

The complainant stated an identified resident's incontinent briefs were not changed regularly, and the resident's urine soaked sheets were left on the bed leaving the resident's room smelling of urine.

FINDINGS:

The resident identified in the complaint no longer resided in the facility at the time of the complaint investigation. The resident resided in the facility during the Recertification, Complaint Investigation and State Licensure survey.

The facility was cited for the Infection Control Program at F441 during the Recertification, Complaint Investigation and State Licensure survey. The facility failed to maintain a sanitary environment and prevent the development and transmission of disease when a resident's pillow was placed on top of a bedside commode and resident's clothing was thrown on the floor.

During this follow-up and complaint survey, the facility was re-cited for the Infection Control Program at F441. The facility failed to ensure infection control measures were implemented to prevent spread of infection by contaminated environmental surfaces, including soiled mattress covers. Odors were prevalent related to the soiled linen.

CONCLUSIONS:

Substantiated. Federal and State deficiencies related to the allegation were re-cited.

ALLEGATION #2:

The complainant stated an identified resident had a fall out of a wheelchair approximately four weeks prior to the complaint and went to the Emergency Room with injuries to the head, face, shoulder and arm. The complainant stated she noticed the resident's wheelchair was now marked with the angle at which the wheelchair must be positioned to prevent the resident from falling out.

FINDINGS:

The identified resident fell from the wheelchair on November 5, 2011, as documented in the facility's report of the incident during the Recertification, Complaint Investigation & State Licensure survey at F323. The facility failed to put effective interventions in place and/or revise care plans to increase supervision as needed to prevent falls resulting in harm to a resident when that resident experienced pain and loss of function as a result of multiple fracture and in the potential for harm to a resident who experienced repeated falls.

In addition, during the follow-up and complaint survey the facility was re-cited for falls at F323. The facility failed to implement physician ordered care planned interventions to prevent falls for a resident. This failed practice had the potential to place residents at risk for future falls, pain and injury.

CONCLUSIONS:

Substantiated. Federal and State deficiencies related to the allegation was re-cited.

ALLEGATION #3:

The complainant stated an identified resident had a feeding tube. The complainant stated the facility pulled out the feeding tube on several occasions but did not know the dates that this occurred. The complainant stated the feeding tube was removed about four weeks prior, and the facility staff failed to assist the resident to eat.

FINDINGS:

The identified resident did not reside in the facility during the investigation of the complaint.

The resident's Interdisciplinary Progress Notes (Nursing Notes) in the closed record documented that the resident's feeding tube became plugged on December 1, 2011, requiring the resident's transfer to the Emergency Department with interventions in the Emergency Department to unplug the feeding tube. Nursing Notes from December 2, 2011, to December 14, 2011, documented the feeding tube was in place and functioning appropriately. On December 14, 2011, the feeding tube was capped as ordered by the physician and used only for medication administration. Nursing Notes from December 14, 2011, until January 3, 2012, documented the capped feeding tube was in place and patent when irrigated until the tube was removed on January 3, 2012, as ordered by the physician.

The survey team observed residents dining for approximately 50 minutes during the evening meal on May 1, 2012. The facility provided sufficient staff to assist residents with dining.

Kelly Spiers, Administrator
May 30, 2012
Page 4 of 5

Residents who required dining assistance were observed to be provided with the assistance they needed during the evening meal.

A Group meeting was conducted on May 2, 2012. Nine residents attended the meeting. Residents were asked if they received adequate help for meals in the dining room. Residents stated they did receive the help they needed to eat during mealtime.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

The complainant stated the identified resident's discharge from the facility was delayed when the facility delayed submitting paperwork to the home health agency. The complainant stated the facility had the resident sign documents that the resident was incapable of understanding and could not give informed consent.

FINDINGS:

The identified resident's did not reside in the facility during the complaint investigation.

The resident's closed record was reviewed. There was no documented evidence that the resident signed consent forms. Consent forms, including forms for self-releasing seat belt, side rails, anti-psychotic medication, scope of treatment, vaccination, lap tray, tilt-in-space wheelchair, notice of transfer or discharge and discharge plan and instructions were signed by the appropriate resident's representative.

A Social Services Director notes dated January 5, 2012, documented the facility started to work with the resident's representative regarding the resident's discharge and had the representative take a more "hands on" approach while the resident was still in the facility. The Social Service Director documented this approach would help the resident, representative and facility work together toward discharge. The notes recorded the ombudsman was working with the resident's representative regarding financial options.

The resident's physician Progress Notes dated January 25, 2012, documented the Physician Assistant would consult with the resident's physician regarding the resident's potential discharge. The notes documented the Physician Assistant's concerns regarding the resident's ability to function in a home setting and the extensive care the resident would require by the representative in that setting.

Kelly Spiers, Administrator
May 30, 2012
Page 5 of 5

The resident's closed record documented a meeting was conducted on February 28, 2012, regarding the resident's discharge. The resident's representative, family members, the ombudsman and the facility's Social Service Director attended the meeting. A home evaluation was scheduled for the next day, February 29, 2012.

Three days later on March 3, 2012, the Social Service Director documented physician's orders were obtained to discharge the resident on March 7, 2012, with services provided by home health, physical and occupational therapy and equipment; including a hospital bed, commode, shower chair, seat belt for tub/shower seat, two ramps, extended tub bench and tilt wheelchair.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

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

Sincerely,

A handwritten signature in black ink that reads "LORENE KAYSER". The letters are somewhat stylized and slanted.

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

LKK/dmj



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
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Boise, ID 83720-0009
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FAX 208-364-1898

August 13, 2012

Kelly Spiers, Administrator
Idaho Falls Care & Rehabilitation Center
3111 Channing Way
Idaho Falls, ID 83404

Provider #: 135107

Dear Mr. Spiers:

On **May 3, 2012**, a Complaint Investigation survey was conducted at Idaho Falls Care & Rehabilitation Center. Lea Stoltz, Q.M.R.P., Lynda Evenson, R.N., and Barbara Daggy, R.N. conducted the complaint investigation.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00005533

ALLEGATION #1:

The complainant stated that an identified agency nurse did not allow an identified Certified Nurse Aide (CNA) to go home or be reassigned when s/he was ill. When the agency nurse was approached for reassignment, staff was told, "If s/he left, it would be his/her job." Another staff was told to shut his/her mouth because the agency nurse was, "...the RN (Registered Nurse)" and CNA staff were not to "undermine" her decisions. The identified CNA was "extremely sick" with a cough, fever, runny nose, sweating and vomiting for over a week, which resulted in her admission to the hospital for steroids and antibiotic treatment. The complainant was not able to provide a diagnosis for the CNAs illness. The CNA attempted to call in sick multiple times but was told s/he had to go in to work even if s/he was sick. Another nurse (identified) tried to talk to the agency nurse about appropriate interactions with CNAs.

Kelly Spiers, Administrator
August 13, 2012
Page 2 of 2

FINDINGS:

A follow-up survey was conducted at the facility on May 1- 3, 2012. The facility failed the follow-up survey and the facility was subsequently decertified from receiving Medicare and Medicaid funding. During that survey, the facility was cited at F441 for failure to implement an effective infection control program to prevent infections in the facility. The facility evidenced confusion and inconsistency regarding infection control requirements for residents known to have active infection with a contagious disease-producing organism, failed to ensure staff washed hands before and after each direct resident contact for which hand washing was indicated by professional standards and failed to ensure infection control measures to prevent spread of infection by contaminated environmental surfaces. F441 requires the facility to have an infection control program to provide an environment to prevent the spread of infection and the development or transmission of disease. The facility cannot provide such an environment if they force staff to work with residents when they have illness that could be contagious.

Long Term Care federal regulations do not have authority over labor disputes. These issues are best reported to the facility's administrator at the time of the incident and/or to the State Department of Labor.

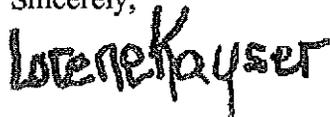
CONCLUSIONS:

Substantiated. Federal and State deficiencies related to the allegation were re-cited during the follow-up revisit.

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

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

Sincerely,



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

LKK/dmj