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: 7009 0820 0000 2798 6925

July 27, 2011

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

Provider #: 135107

Dear Mr. Parker:

On **July 15, 2011**, a Recertification and State Licensure survey was conducted at Idaho Falls Care & Rehabilitation Center 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 one that comprises a pattern 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 2). **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 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 **August 9, 2011.** Failure to submit an acceptable PoC by **August 9, 2011**, may result in the imposition of civil monetary penalties by **August 29, 2011.**

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- Provide dates when corrective action will be completed.

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 **August 19, 2011 (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 **August 19, 2011.** A change in the seriousness of the deficiencies on **August 19, 2011**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **August 19, 2011** includes the following:

Denial of payment for new admissions effective **October 15, 2011.** [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 **January 15, 2012**, 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.

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 **July 15, 2011** 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 - Long Term Care** section and click on **State** and select the following:

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

This request must be received by **August 9, 2011**. If your request for informal dispute resolution

is received after **August 9, 2011**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,

Lorene Kayser

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

LKK/dmj
Enclosures

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

PRINTED: 07/25/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135107	A. BUILDING _____ B. WING _____	07/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO FALLS CARE & REHABILITATION CENTER	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 000	INITIAL COMMENTS The following deficiencies were cited during the recertification survey of your facility. The surveyors conducting the survey were: Lorna Bouse, BSW, Team Coordinator Arnold Rosling, RN, QMRP Amy Beam, RN Survey Definitions: MDS = Minimum Data Set assessment RAI = Resident Assessment Instrument DON/DNS = Director of Nursing LN = Licensed Nurse CNA = Certified Nurse Aide ADL = Activities of Daily Living MAR = Medication Administration Record GDR = Gradual Dose Reduction PA = Physician Assistant	F 000	**F 000 Initial Comments** "This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, **Idaho Falls Care and Rehabilitation Center** does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."	
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and resident interview it was determined the facility did not promote care that enhanced the dignity of 2 of 13 sample residents (#s 2 and 6) when staff entered rooms of Residents #2 and #6 before residents could give permission. Resident #6 was seated in the dining room next to a garbage can and meal cart	F 241	**F-241 Dignity and Respect of Individuality** ***Corrected actions for residents affected:*** Resident #2, 6, 16 and 17 were assessed by Social Services on 08/03/11 to ensure their needs are being met and any concerns identified were addressed.	

RECEIVED
AUG 0 9 2011
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Roger A [signature]	Interim Administrator	08/09/11

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 241	Continued From page 1 used to collect used trays and dishes. In addition, two random observations were completed for Resident #16 who had urine soaked trousers and Resident #17 who had food debris on clothing after a meal. Findings include: 1. Resident #2 was observed in her room on 7/12/11 at 8:20 am. The door to her room was open. LN-1 pushed a medication cart next to Resident #2's room. LN-1 knocked on the open door and as she knocked she walked into the room and over to the resident's bed. LN-1 proceeded to do a blood glucose check on the resident. While LN-1 was finishing the procedure, CNA-2 walked into the resident's room as she knocked on the open door. The resident was never given the opportunity to tell the staff they could enter her room. The resident was able to communicate and could hear well. She was capable of responding to staff when they knocked on her room door. 2. Resident #6 was observed in her room on 7/13/11 at 8:57 am. CNA-3 knocked on the resident's open door and walked into her room. CNA-3 asked the resident if she would like to do her therapy. Resident #6 said, "I might as well." CNA-3 then assisted the resident to sit up on the side of the bed and transferred the resident from the bed to her wheel chair. CNA-3 put the resident's portable oxygen on and took the resident over to her sink where she combed her hair. Resident #6 followed all instructions to transfer to her wheel chair and engaged in conversation with the surveyor as CNA-3 prepared her to go the physical therapy. CNA-3 told the surveyor that she was not a physical therapist assistant but that she was assigned to	F 241	Resident # 16 was provided incontinent care on 7/11/11 by the Certified Nursing Assistant. The Licensed Nurse completed a skin assessment on 07/25/11. Resident #17's clothes were changed by the Certified Nursing Assistant on 07/11/11. ***Identifying other residents having the potential to be affected, and what corrective action will be taken:*** An audit was completed by the Administrator on 08/05/11 related to call bells within residents reach and staff waiting for a response from the resident before entering the resident's room. An observation was completed by Nutrition Services Manager on 08/04/11 related to the cleanliness of residents' clothes after meals. Resident care observations were completed by the Director of Nursing on 08/05/11 to ensure incontinent care is being provided in a timely.	

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F 241	Continued From page 2 get residents ready and bring them to therapy. CNA-3 did not give Resident #6 an opportunity to answer the knock and give permission for entrance to her room. In addition, Resident #6 was observed on 7/14/11 at 8:15 am. CNA-4 assisted the resident to the dining room for breakfast. When they arrived at the dining room, the table where Resident #6 was assigned to sit had a tall gray garbage can placed in Resident #6's seating area. There was a meal cart next to the garbage can and it had dirty meal trays stacked on the top shelf and dirty mugs and glasses on the second shelf under the top shelf. CNA-4 pushed the garbage can slightly out of the way and placed the resident at the end of the table, on the side of the table where she normally sat. Resident #6 was at the very corner of the table and the leg of the table was between her feet. There were two other residents (table mates) who had already been eating while the kitchen equipment was left at the table. To the right of Resident #6 there was a resident with staff sitting by her and providing assistance for her to eat her meal. This was not an environment that fostered dignity and respect during the meal for Resident #6 or the other two residents at the table eating the breakfast meal. 3. Resident #16 was admitted to the facility on 7/7/11 with diagnoses of cardiomyopathy, gastroesophageal reflux disease, chronic prostatitis, depression and anxiety. On 7/11/11 at 6:55 p.m., during the initial tour of the facility, Resident #16 was observed sitting in a wheelchair in his room. The resident was in the entrance way to his room, about eight feet into	F 241	***Measures and systemic changes:*** Staff re-education was completed on or before 8/14/11 by the Administrator and/or Director of Nursing related to maintaining call lights within resident's reach, waiting for a response from the resident when we before we enter their room after knocking, providing timely incontinent care, ensuring that food is removed from residents closes after meals. ***Monitoring corrective action for sustained corrections:*** An audit will be completed by the Department Managers weekly for 1 month and monthly for 2 months to ensure call bells remain within residents reach; staff is waiting for a response from the resident before entering the resident's room; residents' clothes are clean from food after meals and incontinent care is provided timely. A report will be submitted to the Performance Improvement Committee monthly for 3 months. The Administrator is responsible for over all compliance. **Date of Correction for this plan is : 8/15/11**	audits started 8/12/11 per TC c̄ Michelle DON 8/17/11 at 11 AM ASR

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F 241	Continued From page 3 the room. The resident's call system was located on his bed. The resident's wheelchair was positioned against the wall and the lights to the room were off. When the surveyor entered the room, the resident requested assistance to change his pants as the resident had been incontinent of urine. The resident indicated that he only had two pair of pants and the ones he had on were wet and he wanted the other pair put on. The resident appeared stressed with the incontinence episode and not being able to get to the toilet. The DON was informed immediately of the observation and she indicated she would get a staff member to assist the resident. 4. Resident #17 was admitted to the facility on 5/15/09, and readmitted on 10/8/10, with diagnoses which included aftercare for healing traumatic fracture of hip, diabetes type II, and polymyalgia rheumatica. On 7/11/11 at approximately 6:30 PM, during the initial tour of the facility, Resident #17 was observed in her wheelchair in the doorway to her room, facing the hallway and watching hall activity. She had a large amount of white food debris / crumbs covering her lap area including her chest, abdomen, and thighs. There were no CNAs in her vicinity, or evidence that anyone had assisted her to clean up after dinner.	F 241		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and	F 246	**F-246 Reasonable Accommodation of Needs/Preferences** ***Corrected actions for residents affected:*** Residents #16 was assessed by Social Services on 08/03/11 to ensure their needs are being met and the call light was within the resident's reach Resident #18 was assessed by Social Services on 08/03/11 to ensure their needs are being met and the call light was within the resident's reach.	

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F 246	Continued From page 4 preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure that the call bell activator button was accessible for two residents. This was true for 2 random residents (#s 16 & 18). Findings include: 1. Resident #16 was admitted to the facility on 7/7/11 with diagnoses of cardiomyopathy, gastroesophageal reflux disease, chronic prostatitis, depression and anxiety. Review of the "Nursing Assessment", dated 7/7/11, documented the resident's memory as "OK". The resident was oriented to "Place", "Time" and "Situation" and "Decision Making" was "Modified independent." The assessment documented for "Bladder Habit" the resident was continent, and documented for "Transfers" to be a "two person assist." On 7/11/11 at 6:55 p.m., during the initial tour of the facility, Resident #16 was observed sitting in a wheelchair in his room. The resident was in the entrance way to his room, about eight feet into the room. The resident's call system was located on his bed. The resident's wheelchair was positioned against the wall and the lights to the room were off. When the surveyor entered the room, the resident requested assistance to change his pants as he had been incontinent of	F 246	***Identifying other residents having the potential to be affected, and what corrective action will be taken:*** An audit was completed on 08/09/11 by the Administrator related to call lights within resident's reach. Any concerns identified were addressed at this time. ***Measures and systemic changes:*** Facility staff re-education was completed on or before 08/14/11 by the Administrator and/or Director of Nursing related to maintaining call lights within residents' reach and waiting for a response from a resident prior to entering a room. ***Monitoring corrective action for sustained corrections:*** An audit will be completed by the Department Managers weekly for 1 month and monthly for 2 months to ensure call lights are within residents' reach. A report will be submitted to the Performance Improvement Committee monthly for 3 months.	audits started 8/12/11 per DON TC 8/17/11 at 11AM

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F 246	Continued From page 5 urine. The resident indicated that he only had two pair of pants and the ones he had on were wet and he wanted the other pair put on. The resident indicated that he was not sure where the call bell was located. 2. Resident #18 was admitted to the facility on 1/6/07 and readmitted on 9/11/09, with diagnoses of unspecified delay in development, muscle weakness (generalized), abnormality of gait, convulsions, depressive disorder and other syndrome affecting cervical region. On 7/11/11 at 6:45 p.m., during the initial tour of the facility, Resident #18 was observed sitting in a wheelchair in his room. The resident was in the entrance way to his room, about six feet into the room. The resident's call system was located on his bed. The resident's wheelchair was positioned by the wall and he was moving it back and forth in place. The lights to the resident's room were off. The resident appeared to have decreased vision in the right eye. When the surveyor entered the room the resident requested assistance to go to bed. He indicated that he did not know where the call light was located.	F 246	The Director of Nursing is responsible for overall compliance. **Date of Correction for this plan is : 8/15/11**	
F 252 SS=D	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by:	F 252	**F-252 Safe/Clean/Comfortable/ Homelike Environment** ***Corrected actions for residents affected:*** Low air loss mattresses in room 208 were immediately changed out for both residents on 07/12/11 by the Environmental Services Supervisor. Residents in room 208 were assessed by Social Services on 08/09/11 to ensure their needs are met and any concerns identified were addressed.	

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F 252	Continued From page 6 Based on observation and staff interview, it was determined the facility failed to ensure that the urine odor outside and inside room 208 was not present. This affected 1 of 15 rooms (room #208) on the 200 hallway. Findings include: During the initial tour of the facility on 7/11/11 at 6:45 p.m. there was a strong smell of stale urine in the hallway outside room 208. Upon entering the room the odor was really strong of old urine. The morning of 7/12/11 the stale urine smell continued to linger inside and outside room 208. At 9:45 a.m. the DON was informed of the odor. Both the surveyor and DON went to the room and she agreed there was a problem. At 9:50 a.m. housekeeping staff were seen changing the air mattresses on the two beds that were in the room. On 7/14/11 at 9:00 a.m. the room and hallway were checked and the odors were not present.	F 252	***Identifying other residents having the potential to be affected, and what corrective action will be taken:*** An audit was conducted by the Administrator and Environmental Services Supervisor on 07/12/11 related to odor with low air loss mattresses and changes made as needed. ***Measures and systemic changes:*** Housekeeping staff have been re-educated to daily cleaning and cleaning protocols on or before 08/14/11 by the Environmental Services Supervisor. Resident rooms with low air loss mattresses have been identified and scheduled for cleaning. Nursing staff re-educated to ensure linens are changed during incontinent episodes, if there is visible soiling and per the weekly schedule.	
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 medical record review and staff interview, the facility failed to:	F 309	***Monitoring corrective action for sustained corrections:*** Environmental rounds will be completed by Environmental Services Supervisor &	

Environmental rounds started 7/14/11 pm

TC c̄ DON 8/17/11 at 11AM ASR

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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 medical record review and staff interview, the facility failed to:	F 309	**F- 309 Provide Care/Services For Highest Well Being** ***Corrected actions for residents affected:*** Residents #5's Care Plan was updated with Hospice services on 7/14/11 by the Director of Nursing and placed in the medical record. Resident #8's Care Plan was updated with Dialysis services on 08/09/11 by the Director of Nursing and placed in the medical record. Resident #8's dialysis communication sheets were obtained from dialysis center on concurrent visits.	

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F 309	Continued From page 7 *Ensure collaboration of care and care plan development in conjunction with the hospice agency for Resident #5, *Ensure collaboration of care and care plan development in conjunction with the dialysis center for Resident #8. This was true for 1 of 1 (# 5) resident who received hospice services and 1 of 1 (# 8) resident who received dialysis. Findings include: 1. Resident #5 was admitted to the facility on 6/1/09 and readmitted on 10/7/10 with diagnoses of pressure ulcer buttock, diabetes without neurological manifestation type II, and poly neuropathy in diabetes. The resident's most recent significant change assessment, dated 5/26/11, documented the resident was: * severely cognitively impaired, * required extensive to total assist of one staff for transfers, ambulation, eating, personal hygiene and bathing, * totally incontinent of bowel and bladder, * receiving hospice services. There was no evidence in the medical record that the facility and the hospice agency had developed a joint care plan for the resident. In addition, the medical record did not include of documentation of hospice nursing visits. The hospice agreement with the facility documented at Section 6: "Mutual Rights, Duties, and Obligations of the Parties": Subsection 6.1: "Development and Implementation of Plan of Care."	F 309	***Identifying other residents having the potential to be affected, and what corrective action will be taken:*** An audit was conducted on 08/02/11 by the Administrator to identify other residents on hospice and dialysis to ensure care plans are up to date and in the medical record. ***Measures and systemic changes:*** The Licensed Nurses were re-educated on or by August 14, 2011 by the Director of Nursing related to the requirements of Hospice and Dialysis care plans and the requirements of dialysis communication sheets to included maintaining care plans and communication sheets in the medical records. ***Monitoring corrective action for sustained corrections:*** Care Plan audits will be completed weekly for 1 month and monthly for 2 months by the Director of Nursing or Designee related to residents receiving hospice care or dialysis to ensure care plans are coordinated with the service provider and implemented within the center,	

audits started 8/2/11 pls tc c̄ DON 8/17/11 at 11am

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	135107		07/15/2011

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F 309	Continued From page 8 "When a Center resident is authorized by Hospice for admission to the Hospice Program, or when the Center admits a Hospice Patient to the Center, Hospice and Center shall jointly develop and agree upon the Patient's POC [Plan of Care]. Hospice shall retain overall professional management responsibility for directing the implementation of each Patient's POC....Hospice and Center each shall maintain a copy of each Patient's POC in the respective clinical records maintained by each party. Each Hospice and Center shall designate a responsible representative, responsible for coordinating the implementation of the POC for each Patient and ensuring communications between the Hospice and the Center." Subsection 6.2: "Modification of Plan of Care." "Hospice and Center shall jointly coordinate and participate in periodic review and modification of each Patient's POC at intervals specified in the POC, taking into account any changes in the Patient's conditions. Each of Hospice and Center shall document the review and modification of each POC...." The DON was notified of the lack of POC and documentation from the hospice agency on 7/14/11 at 8:15 a.m. Prior to the end of the survey, the hospice agency faxed a copy of their POC to the facility but neither the facility care plan or the hospice care plan were completed in collaboration with each other as outlined in the contract. 2. Resident #8 was admitted to the facility 9/26/08, and readmitted 3/17/10, with diagnoses of chronic kidney stage V, diabetes with neuro	F 309	as well as dialysis communication sheets are completed and in the medical record. A report will be submitted to the Performance Improvement Committee monthly for 3 months The Director of Nursing is responsible for overall compliance. **Date of Correction for this plan is : 8/15/11**	

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F 309	Continued From page 9 manifestations type II, and unspecified peripheral vascular disease. The most recent quarterly MDS, dated 5/27/11, documented the resident: * was severely cognitively impaired, * required extensive assistance of one staff for transfers, ambulation, dressing, personal hygiene and bathing, * was totally incontinent of bowel and bladder, and * did not have documented behaviors. The resident's medical record lacked documentation of coordination between the facility and the dialysis unit about the care and problems encountered during the dialysis visit. The record did not include evidence of a comprehensive care plan that was developed jointly between the facility and the dialysis center. The dialysis unit's contract with the facility specified the following: Section 1. "Rights, Duties, and Obligations of Center and Provider." 1.4 Care Plan. "(a) Development and Implementation. When a Center resident with renal disease requiring dialysis is authorized by Center to receive Services from Provider, Provider and Center shall jointly develop and agree upon the Center resident's care plan appropriate for management of end stage renal disease and pertinent Services. Provider shall retain overall professional management responsibility for implementing and monitoring Services in accordance with the Center resident's care plan. Center shall be responsible for implementing	F 309		

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F 309	Continued From page 10 non-Services portions of the Center resident's care plan, including but not limited to nutritional needs, addressing emotional and social needs and monitoring aspects of the patient's condition and care pertinent to the nature of end stage renal disease." "(b) Maintenance and Review. Provider and Center each shall maintain a copy of each Center resident's care plan in each party's respective clinical records. Provider and Center shall each designate a staff member responsible for coordinating the implementation of the care plan for each Center resident receiving Services. Provider and Center shall jointly coordinate and participate in periodic review and modification of each Center resident's care plan as the care plan appertains to dialysis services at intervals specified in the care plan.... Provider and Center shall document the review and modification of each Center resident's care plan...." The DON was notified of the lack of a plan of care and documentation from the dialysis center on 7/14/11 at 8:15 a.m. The DON did not provide any further information related to the dialysis provider being involved in developing a plan of care.	F 309		
F 323 SS=D	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.	F 323	**F- 323 Free of Accident Hazards/Supervision/Devices** ***Corrected actions for residents affected:*** Resident #1's care plan was reviewed by the Director of Nursing on 07/14/11 with new interventions implemented as identified.	

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F 323	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to identify hazards, evaluate and analyze risks, and/or implement, monitor, and revise interventions to prevent falls for a resident with a history of weakness, was a high fall risk, and had actual falls in the facility. This was true for 1 of 12 sampled residents reviewed for falls (#1). Findings included: Resident #1 was admitted to the facility on 4/7/11 with diagnoses which included Alzheimer's disease, dementia, palliative care, coronary artery disease, and chronic pain. The resident's 4/12/11 Admission MDS assessment coded: * Severe cognitive impairment * Extensive assistance by 2 or more staff for transfers * Did not walk in or out of her room * Extensive assistance by 1 person for toilet use * Not steady, only able to stabilize with human assistance for moving from seated to standing position, moving on and off toilet, and surface-to-surface transfers * Wheelchair used for mobility * Frequently incontinent of urine, always continent of bowel * No fall history in prior 6 months, and no falls since admission The resident's 4/20/11 Care Plan documented a 4/7/11 focus of risk for falls related to unstable health condition, pain, and general weakness.	F 323	***Identifying other residents having the potential to be affected, and what corrective action will be taken:*** Residents residing in the center that have fallen within the past 3 months have been identified and care plans reviewed by the Director of Nursing on 08/09/11 for current interventions and supervision. ***Measures and systemic changes:*** Licensed nurses were re-educated on or by 08/14/11 by the Director of Nursing related to the requirements of interventions related to falls and risk for falls, to include updating the care plan to reflect current interventions. ***Monitoring corrective action for sustained corrections:*** Fall care plans will be audited weekly for 1 month then monthly for 2 months by the Director of nursing or designee to ensure care plans are updated with current interventions. A report will be submitted to the Performance Improvement Committed monthly for 3 months. The Director of Nursing is responsible for overall compliance.	audits started 8/9/11 pm tc c̄ DON on 8/17/11 at 11AM

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F 323	Continued From page 12 The goal was, "no significant injury related to a fall." Interventions initiated on 4/7/11 were: * Ensure environment is free of clutter * Place call light within easy reach of resident * 1/4 side rails up x 2 as enablers to aid with bed mobility * Pressure alarm while in bed * Pressure alarm while in chair A hand written entry, dated 6/2/11, documented the additional intervention of "bed in lowest position." No other interventions for falls were documented. The resident's 4/4/11 History and Physical Examination report documented, "She has become progressively weaker and requires assistance now getting from a chair or bed into the bathroom for toileting or for bathing." Resident Fall Evaluations were completed upon admission to the facility on 4/7/11, and after a fall on 6/2/11. The resident's 4/7/11 Admission Nursing Assessment documented: * Numbness of the feet * Tingling of the legs and feet * Short and long term memory problems * Severely impaired decision making * Does not ambulate * Transfers with 2 person assist * Not steady, only able to stabilize with human assistance during transitions and walking A 6/2/11 Change of Condition Documentation form documented that the resident had an unobserved fall at 8:37 PM on that date. "Resident's alarm sound (sic) and when aide	F 323	**Date of Correction for this plan is : 8/15/11**	

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F 323	Continued From page 13 responded [resident] was sitting on floor by [bathroom]. [Resident] stated she lost her balance on her way to [bathroom]. Denies injury or hitting head, no injury noted. [Resident] has full [range of motion and] denies pain. [Resident] educated to wait for assistance to ambulate." An Event Management Report documented the fall as above. The report documented, "Bed will be in the lowest position." The Root Cause Conclusion was, "Resident is confused and she is in declining state of dementia, she does not remember to use her call light. The resident has been working with physical therapy and she is getting a little stronger and she thinks she is able to transfer herself to the bathroom." Interdisciplinary Progress Notes documented the following entries related to falls and the resident's attempts to self-transfer: * 5/1/11 at 9:00 PM - "Attempted self transfer to [bathroom]. Alarm sounding. Aide went to help. [Resident] became very hostile and yelling, 'I put myself on the toilet for years and will continue to do that." * 5/28/11 at 10:00 PM - "Has been trying to self transfer several times this evening. Alarms in place and function... limited assist [with] transfers." * 6/10/11 at 10:30 PM - "Has had several attempts self transferring. Alarms in place and functioning." * 6/28/11 at 11:00 PM - "Non-compliant in transfers and ambulation." * 6/29/11 at 11:00 PM - "Non-compliant in asking for help with ambulation." The resident's Care Plan did not address her	F 323		

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F 323	Continued From page 14 attempts to self-transfer, which she was documented to do both before and after her fall and occurred when the resident attempted to self-transfer to the bathroom. The only revised intervention on the Care Plan after the fall was to maintain the bed in the lowest position, which would not address her attempts to self-transfer other than the reduce the level of harm if she fell when getting out of bed. The DON and Administrator were advised of the findings on 7/13/11 at 4:00 PM. On 7/14/11, the DON stated that the resident had alarms in place since admission, "because of self-transferring." She stated that the nurse most frequently assigned to the resident's hall "parks her cart at the end of the hall to monitor her better," and then concluded that if the Care Plan specifically addressed the resident's attempts to self-transfer and what interventions were effective, all staff would be better aware of the risks and interventions.	F 323		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.	F 328	**F-328 Treatment/Care for Special Needs** ***Corrected actions for residents affected:*** Resident #6 was assessed by a Licensed Nurse on 07/14/11related to respiratory status with no change in the residents condition noted.	

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F 328	Continued From page 15 This REQUIREMENT is not met as evidenced by: Based on observation and record review it was determined the facility did not ensure physician's orders for administration of oxygen were implemented consistently for 1 of 6 sampled residents (# 6) who received treatment with oxygen. Findings include: Resident #6 was admitted to the facility on 5/27/11 after falling at home and fracturing four ribs on her left side. The resident was hospitalized, developed pneumonia and was admitted to the facility for after care and physical therapy. The physician's orders for the month of July 2011 documented, "[Oxygen/nasal canula, at 4 liters per minute. Check liter flow every shift and document. Check saturation levels as needed for signs/symptoms of respiratory distress]." The start date for the order was 5/27/11. The following observations were made for Resident #6: *7/12/11 at 10:50 am. The resident was in her room asleep and receiving oxygen from a concentrator in her room. The oxygen liter flow was set for 4 liters a minute. *7/13/11 at 8:15 am. The resident was in the dining room and receiving oxygen from a portable oxygen tank hooked to the back of her wheel chair. The oxygen was set for 2 liters per minute. *7/13/11 at 8:57 am. The resident was taken to the physical therapy room for her exercises. The portable oxygen tank was set on 2 liters per minute. The resident was observed on an exercise machine with the oxygen set at 2 liters	F 328	***Identifying other residents having the potential to be affected, and what corrective action will be taken:*** An audit was completed by the Administrator on 08/04/11 to ensure residents are receiving oxygen as ordered. ***Measures and systemic changes:*** Licensed staff were re-educated on or before 08/14/11 by the Director of Nursing related to the requirements of maintaining oxygen settings as ordered by the physician. Settings for residents on oxygen were provided to therapy and the dining room for staff to monitor that oxygen is provided as ordered. ***Monitoring corrective action for sustained corrections:*** Audits of oxygen settings will be conducted by Department Managers weekly for one month and monthly for 2 months. A report will be submitted to the Performance Improvement Committee monthly for 3 months. The Director of Nursing is responsible for overall compliance. **Date of Correction for this plan is : 8/15/11** audit started 8/4/11 per TC DON 8/17/11 @ 11AM AG	

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F 328	Continued From page 16 per minute. *7/13/11 at 12:25 pm. The resident was in the dining room. Her portable oxygen was set for 2 liters per minute. The DON was asked to provide the directives provided to the aides for ADL care and any other responsibilities they had directions to perform. The DON provided a copy of a "Nursing Assistant Care Card." The form identified that the resident received, "oxygen at 4 liters." The resident was not receiving the oxygen as ordered by her physician.	F 328		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 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.	F 329	**F-329 Drug Regimen is Free From Unnecessary Drugs** ***Corrected actions for residents affected:*** Resident #5's anti-anxiety was clarified on 08/09/11 by the Licensed Nurse to include justification of medications. The Pharmacy recommendation was addressed by the physician on 08/09/11. Resident #6's behavior monitoring tool was implemented on 08/04/11 by the Director of Nursing to include monitoring hours sleep. Resident's respiratory status and anxiety level was assessed by the Licensed Nurse on 07/15/11. Resident #8's antipsychotic was clarified on 08/09/11 by the Director of Nursing to include justification of medication.	

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F 329	Continued From page 17 This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, it was determined the facility failed to: * Provide justification for and monitor the use of a an antihistamine H-1 blocker ordered for sleep and monitor for an anti-anxiety medication for Resident #6, * Provide justification for the use of antipsychotic medication for Resident #8 and attempt a GDR, * Provide justification for the use of antianxiety medication for Resident #5 and attempt a GDR, * Monitor behaviors for Residents #3 and #14 who received medication to control behavior. This was true for 5 of 13 (#s 3, 5, 6, 8 and 14) sampled residents. Findings include: 1. Resident #5 was admitted to the facility on 6/1/09 and readmitted on 10/7/10 with diagnoses of pressure ulcer (buttock), diabetes without neurological manifestation type II, and poly neuropathy in diabetes. The resident's most recent significant change MDS, dated 5/26/11, documented the resident was: * severely cognitively impaired, * required extensive to total assist of one staff for transfers, ambulation, eating, personal hygiene and bathing, * totally incontinent of bowel and bladder, * receiving hospice services.	F 329	Residents #3,5,6 and 8's behavior monitoring sheets were implemented by Licensed Nurse on 08/04/11. Resident #14's behavior monitoring sheet was implemented by the Licensed nurse on 7/12/11. ***Identifying other residents having the potential to be affected, and what corrective action will be taken:*** An audit was conducted on 08/01/11 by the Director of Nursing to determine which residents on antipsychotics needed to have tracking sheets initiated. Pharmacy recommendations reviewed for MD assessment and re-sent as needed for appropriate MD interventions/signatures. ***Measures and systemic changes:*** Social Services educated on psychotropic drug use and behavior tracking to ensure continued use is justified on or before 08/14/11. Licensed staff and CNAs educated on or before 08/14/11 on the necessity of documenting resident behaviors identified so proper treatment can be provided. Physician education provided to MDs by	

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F 329	Continued From page 18 The resident's medical record contained a 5/31/11 physician's order for Ativan 0.5 mg tablet by mouth twice a day. This order was an increase from a physician's order, dated 10/7/10, which prescribed Ativan 0.25 mg three times a day for anxiety. On 4/12/11 the pharmacist made a recommendation that the facility do a GDR on the Ativan. The PA's documented response was, "[Resident #5's] mood has been stable." There was no explanation how the PA came to the conclusion that the resident's mood was stable. The resident's attending physician failed to respond to the pharmacist's recommendations. 2. Resident #8 was admitted to the facility on 9/26/08, and readmitted 3/17/10, with diagnoses of chronic kidney stage v, diabetes with neuro manifestations type II, and unspecified peripheral vascular disease. The most recent quarterly MDS assessment, dated 5/27/11, documented the resident: * was severely cognitively impaired * required extensive assistance of one staff for transfers, ambulation, dressing, personal hygiene and bathing. * was totally incontinent of bowel and bladder, and * did not have documented behaviors. The resident's medical record contained a 7/8/10 physician's order for Risperdal 0.5 mg by mouth twice a day. The resident had been on the medication for a	F 329	08/14/11 to ensure drug regimen reviews are reviewed timely and physician responses are addressing pharmacist's recommendations appropriately. ***Monitoring corrective action for sustained corrections:*** Social Services will audit behavior tracking forms weekly for 4 weeks for 1 month and monthly for 2 months to verify behaviors are tracked appropriately. Tracking forms will be initiated at the first of each month and upon onset of new behaviors as identified by Social Services, who will educate staff of new behavior tracking. The Social Services Director will be responsible for overall compliance of behavior tracking and the Director of Nursing will be responsible for overall compliance of pharmacy recommendations. **Date of Correction for this plan is : 8/15/11**	audits started 8/15/11 pm TC c̄ DON 8/17/11 at 11AM ASR

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F 329	Continued From page 19 year and there was no documentation in the medical record that the facility had attempted a GDR for the medication. Review of the resident's 5/27/11 quarterly MDS, 2/28/11 annual MDS and June 2011 and July 2011 behavior monitoring records revealed the resident had no documented behaviors since before February 2011. 3. Resident #3 was admitted to the facility on 3/31/11, and readmitted on 6/5/11, with diagnoses of closed fracture of dorsal vertebra without mention spinal cord injury, closed fracture lumbar vertebra without mention spinal cord injury, closed fracture sacrum and coccyx without mention spinal cord injury and other persistent mental disorder due to conditions classified elsewhere. The most recent significant change MDS assessment, dated 4/20/11, documented the resident: * was severely cognitively impaired, * required extensive assistance of one staff for transfer, dressing, personal hygiene and bathing, * was continent of bowel and bladder, and * had no documented behaviors. The resident's medical record contained a 6/1/11 PA order for Risperdal 0.5 mg by mouth twice a day. The PA wrote a diagnoses of, "Dementia with agitation." The medical record lacked documentation that the facility was monitoring the use of the Risperdal nor was there documentation of the resident's "agitation." The DON was informed of the lack of monitoring	F 329		

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F 329	Continued From page 20 the behaviors on 7/14/11 at 8:15 a.m. The behavior monitoring was started on the resident as a response to the interview. 4. Resident #14 was admitted to the facility on 6/29/11 with diagnoses of fractured fibia and tibia, schizophrenia and diabetes mellitus type I. The admission MDS, dated 7/5/11, documented the resident: * had moderate impairment for cognition, * had behaviors of rejecting care at least daily, * required minimal to no help with transfers, dressing, eating and personal hygiene, and * was continent of bowel and bladder. The resident's medical record contained a 6/29/11 physician's order for Fluoxetine HCL 20 mg by mouth daily for schizophrenia, Clozapine 200 mg two time a day for schizophrenia, Divalproex Sodium 1000 mg two times a day for schizophrenia and Seroquel 500 mg one time a day at bedtime for schizophrenia. The resident's MAR had a Behavioral Drug Monthly Flow Record. The resident's behaviors to be monitored were "Hears Voices", "Talks to himself" and "resistive to cares." The monitoring did not start until 7/12/11. The DON was informed of the lack of monitoring the behaviors on 7/14/11 at 8:15 a.m. No further information was provided. 5. Resident #6 was admitted to the facility on 5/27/11 after falling at home and fracturing four ribs on her left side. The resident was hospitalized, developed pneumonia and was	F 329		

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F 329	Continued From page 21 admitted to the facility for after care and physical therapy. a) The physician's orders for the month of July 2011 documented, [Benadryl (diphenhydramine HCl) 25 milligram capsule by mouth (oral) - as needed: every bedtime as needed for sleep]." The start date for this medication was 6/21/11. Behavioral monitors were reviewed for the month of June and July 2011. There was no baseline for how much the resident was not sleeping before she was placed on the Benadryl. There was no documentation of hours of sleep for the resident to indicate how well the resident was sleeping at night since she started taking the Benadryl in July. Nurse's notes were reviewed from the resident's date of admission on 5/27/11 to the most current date in the record which was 6/23/11. There was no documentation regarding the resident having difficulty sleeping. There was not adequate indication for use of this medication. The guidance at F329 classifies Benadryl as an antihistamine H-1 blocker. Documentation further indicates the medication has "strong anticholinergic properties and are not considered medications of choice in older individuals." The resident was of an advanced age. Adverse consequences were listed as "excessive sedation, confusion, cognitive impairment, dry mouth, constipation, urinary retention. These may lead to other adverse consequences such as falls. The resident was observed to be very tired	F 329		

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F 329	Continued From page 22 throughout the survey observation days of July 11 through July 14, 2011. On 7/12/11 the resident told the surveyor that she was "so tired." Family members were visiting her at the time and said she seems to be like this a lot and just tells us to say, "Wake up." Meal observations revealed the following: On 7/13/11 at 8:15 am, the resident just ate some toast for breakfast and immediately requested to go back to her room and lay down so she could sleep. Later at lunch (12:25 pm) she put her head on the dining room table and fell asleep. This same scenario happened at breakfast the next morning on 7/14/11 at 8:15 am. The DON was interviewed on 7/12/11 at approximately 2:30 pm, about the use of Benadryl for Resident #6. The DON agreed it was contraindicated in the elderly. The record did not contain a pharmacy recommendation as the monthly review was completed before the medication was started and the July review was not completed yet. The DON said she would look into it and provide more information. She informed the surveyor later at 10:37 am that the physician had been called and discontinued the Benadryl for Resident #6 and started her on Melatonin instead. b) In addition, the resident had a physician order for "[Xanax (Alprazolom) 0.25 milligram tablet, by mouth], prn [as needed, every eight hours for anxiety. Anxiety related to shortness of breath]." The start date was 6/4/11. Nurse's notes contained the following documentation: 5/31/11, 7:00 pm- "Resident is [complaining of,	F 329		

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F 329	Continued From page 23 shortness of breath]. Resident is on 4 [liters per minute, per nasal canula]. Right middle lobe crackles noted. All other lobes are clear. Respirations were counted [at] 4 pm and then 6 pm. MD and family notified." 6/4/11, 1:35 pm- "Received orders for [by mouth] xanax for anxiety r/t [related to, shortness of breath]." This was the first nurse note since 5/31/11 that indicated the resident had complained of shortness of breath. However, it was noted on 6/1/11 (IDT note) the resident was "...alert and oriented and able to make her needs known..." The MAR for June 2011 documented the resident received the Xanax almost daily with only days 6, 23 and 29 that she did not receive the medication. She frequently received the medication more than one time a day. When compared to the behavioral documentation the resident had no anxiety noted on day 6, 23 or 29. Other days that there were no anxiety symptoms were days 7, 18, 20, 21, 22, 24, 25, 26, 28 and 30. However, the medication was administered on all these days. The MAR did not have any documentation related to why she received the prn medication on these days and did not document any improved outcomes after she received the medication. The MAR for July 2011, documented the resident received the Xanax on days 1, 2, 3, 4, 5, 7, 10 and 12. The medication was only administered one time on each day. The behavioral monitor form for July 2011 documented the resident had anxiety due to shortness of breath, on days 1 and 2 and possibly day 11 [illegible entry] only.	F 329		

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F 329	Continued From page 24 Documentation in the nurse progress notes did not support that the resident asked for the medication due to anxiety or that the resident was observed to be anxious due to shortness of breath. As in the prior month, there was no documentation on the back of the MAR to indicate the reason for administration of the prn medication or effectiveness of the medication. The data was reviewed with the DON on 7/12/11 at approximately 2:30 pm. She agreed the data did not support the administration of the prn medication Xanax for Resident #6.	F 329		
F 386 SS=E	483.40(b) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the physician and physician's assistant (PA) failed to sign and date progress notes which were dictated and transcribed after each visit. This was true for 5 of 14 sample residents (#s 5, 7, 8, 9, and 12). Findings included: 1. Resident #7 was admitted to the facility on	F 386	**F- 386 Physician Visits - Review Care/Notes/Orders** ***Corrected actions for residents affected:*** PA and/or MD reviewed charts for Resident's #5, 7, 8, 9, & 12 on 08/09/11 and signed /initialed progress notes. ***Identifying other residents having the potential to be affected, and what corrective action will be taken:*** An audit was completed on 08/09/11 by Health Information for transcribed physician notes for signatures, dates, and/or initials. ***Measures and systemic changes:*** The Administrator provided the PA, MD and transcriptionist by 08/14/11a copy of this regulation and discussed the need to have transcribed progress notes personally or electronically signed. Notes received by facility to be reviewed by health information for signatures/initials prior to placing in resident charts.	

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F 386	Continued From page 25 7/23/08, and readmitted on 2/2/11, with diagnoses which included quadriplegia, recurrent urinary tract infections, neurogenic bladder with indwelling catheter, and a history of epilepsy and seizures. The resident's medical record contained progress notes dictated by the PA on the following dates. None of the transcribed notes were signed by the PA after they had been typed. * February 3, 4, 8, 17 (2 notes), 23, and 24, 2011 * March 1, 15, 18, and 21, 2011 * April 5 and 6, 2011 * May 3, 26, and 31, 2011 * June 17 and 23, 2011 Additionally, the resident's medical record contained progress notes dictated by the physician on 2/24/11 and 6/28/11, which were not signed by the physician after they had been typed. 2. Resident #9 was admitted to the facility on 2/24/09, and readmitted on 5/28/10, with diagnoses which included shortness of breath, pulmonary edema, congestive heart failure exacerbation, urinary tract infection, diabetes mellitus, and hypertension. The resident's medical record contained progress notes dictated by the PA on the following dates. None of the transcribed notes were signed by the PA after they had been typed. * March 15 and 22, 2011 * April 4, 5, 7, 8, 19, 25, 27, and 28, 2011 * May 4, 6, 10, 17, 18, 19, 23, 25, and 31, 2011 * June 15, 17, 20, and 23, 2011 Additionally, the resident's medical record contained a progress note dictated by the	F 386	***Monitoring corrective action for sustained corrections:*** Random audits to be conducted by health information manager once a week for 4 weeks and monthly for 2 months for compliance with signed progress notes in medical records. Medical Records will be responsible for overall compliance. **Date of Correction for this plan is : 8/15/11**	audits started 8/11/11 per TC & DON 8/17/11 at 11A KM

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F 386	Continued From page 26 physician on 3/29/11, which was not signed by the physician after it had been typed. 3. Resident #12 was admitted to the facility on 5/6/11, and readmitted on 5/31/11, with diagnoses which included rehabilitation, convulsions, symbolic dysfunction, adult failure to thrive, and atrial fibrillation. The resident's medical record contained progress notes dictated by the PA on the following dates. None of the transcribed notes were signed by the PA after they had been typed. * May 10, 11, 19, 23, and 24, 2011 * June 1, 15, 16, 17, and 21, 2011 The DON and Administrator were advised of the findings on 7/14/11 at 8:30 AM. The DON stated that the physician and PA use a tape recorder to dictate their progress notes, and then the tapes are picked up and transcribed by a transcriptionist. No further information was received from the facility. 4. Resident #5 was admitted to the facility on 6/1/09 and readmitted on 10/7/10 with diagnoses of pressure ulcer buttock, diabetes without neurological manifestation type II, and poly neuropathy in diabetes. The resident's medical record contained progress notes dictated by the PA on the following dates. None of the transcribed notes were signed by the PA after they were typed. * March 22, 2011 * April 5, 18, 22, 25, 29, 2011 * May 2, 6, 10, 12, 16, 19, 24, 2011 * June 20, 29, 2011	F 386		

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F 386	Continued From page 27 * July 11, 2011 Additionally, the resident's medical record contained a progress note dictated by the physician on 3/29/11 which was not signed by the physician after it had been typed. 5. Resident #8 was admitted to the facility 9/26/08, and readmitted 3/17/10, with diagnoses of chronic kidney stage V, diabetes with neuro manifestations type II, and unspecified peripheral vascular disease. The resident's medical record contained progress notes dictated by the PA on the following dates. None of the transcribed notes were signed by the PA after they had been typed. * May 3, 6, 10, 12, 23, 26, 31, 2011 * June 16, 21, 23, 2011 Additionally, the resident's medical record contained a progress note dictated by the physician on 6/28/11 which was not signed by the physician after it had been typed. The DON and Administrator were advised of the findings on 7/14/11 at 8:30 AM. The DON stated that the physician and PA use a tape recorder to dictate their progress notes, and then the tapes are picked up and transcribed by a transcriptionist. No further information was received from the facility.	F 386		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to	F 428	**F-428 Drug Regimen Review, Report Irregular, Act On** ***Corrected actions for residents affected:*** Residents #1 & #8 drug regimen reviewed by pharmacy consultant for regimen appropriateness. Pharmacy recommendations resent to the MD(s) for review and appropriate responses.	

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F 428	Continued From page 28 the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to act upon irregularities reported by the pharmacist for Resident #1. In addition, the pharmacist had not made a recommendation for a GDR or change in medication for approximately ten months after the physician declined a GDR for Resident #8. This was true for 2 of 14 surveyed residents (#s 1 and 8). Findings included: 1. Resident #1 was admitted to the facility on 4/7/11 with diagnoses which included Alzheimer's disease, dementia, palliative care, coronary artery disease, and chronic pain. The resident's medical record contained a 4/7/11 physician's order for Ativan 0.5 mg (milligrams) by mouth every 4 hours PRN (as needed) for anxiety. The resident's Medication Regimen Review form documented 3 monthly reviews by the pharmacist, which included the following comments: * 4/12/11 - "[Decrease] Ativan to 0.5 mg [every 6 hours] PRN. See report for any noted irregularities and/or recommendations." * 5/10/11 - No comments, and the "NI" box was checked to indicate that no irregularities were	F 428	***Identifying other residents having the potential to be affected, and what corrective action will be taken:*** An audit was conducted on 07/31/11 by the director of nursing to determine which residents need to have pharmacy recommendations reviewed by MD. ***Measures and systemic changes:*** The Administrator discussed the pharmacy report with the MD and/or PA and on need to review and document regarding pharmacy recommendation. ***Monitoring corrective action for sustained corrections:*** Random audits to be conducted by Health Information Manager once a week for 4 weeks and monthly for 2 months for compliance with signed and documented pharmacy recommendations; discrepancies will be reported to the Director of Nursing for physician follow up. The Director of Nursing is responsible for overall compliance. **Date of Correction for this plan is : 8/15/11**	audits started 8/15/11 pn tc c̄ DON on 8/17/11 at 11AM

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F 428	Continued From page 29 found, or recommendations indicated. * 6/14/11 - "[Decrease] Ativan.... See report for any noted irregularities and/or recommendations." Pharmacist's Consultation Reports dated 4/12/11 and 6/14/11 both documented: "The recommended maximum daily dose threshold for this medication used to treat anxiety as outlined in F329 is 2 mg/24 hours. Recommendation: Please re-evaluate continued use of Ativan at this dose, perhaps decreasing to 0.5 mg [every 6 hours] PRN. If this medication is to continue at the current dose, it is recommended that a) the prescriber document an assessment of risk versus benefit, indicating that it continues to be a valid therapeutic intervention for this individual; and b) the facility interdisciplinary team ensure both ongoing monitoring for potential adverse consequences and implementation and monitoring of resident-specific non-pharmacologic interventions." The forms were signed by the DON on 4/18/11 and 6/20/11 respectively, but the lines for the physician to sign and date both forms were blank. The DON was advised of the findings on 7/13/11 at 12:00 PM. The DON provided documentation that the physician was faxed the 6/14/11 Consultation Report on 6/20/11, 6/27/11, and 7/6/11; but there was no documentation to support that the physician had responded in any way. The DON and Administrator were advised of the findings on 7/13/11 at 4:00 PM. The DON provided a revised copy of the 6/14/11 Consultation Report, which the physician had signed but not dated. Additionally, new physician	F 428		

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F 428	Continued From page 30 orders were received on 7/13/11 which decreased the Ativan to every 6 hours PRN as suggested by the pharmacist. 2. Resident #8 was admitted to the facility 9/26/08, and readmitted 3/17/10, with diagnoses of chronic kidney stage V, diabetes with neuro manifestations type II, and unspecified peripheral vascular disease. The resident's medical record contained a 7/8/10 physician's order for Risperdal 0.5 mg by mouth twice a day everyday. A Pharmacist Consultation Report dated 9/14/10 documented: "Recommendation: Is this medication still necessary for this resident(s) care, or could it be discontinued, or changed to a safer alternative? If it is to continue, please document a statement of risk versus benefits." The form further documented: "Rationale for Recommendation - The Food and Drug Administration (FDA) has released a public health advisory and required product manufacturers to include a BOXED warning in the prescribing information for all antipsychotic medications which warns of the potential for increased mortality when antipsychotic medications are used in elderly individuals with dementia-related behavioral disorders." "Physician's Response: I decline the recommendation(s) above and do not wish to implement any changes due to the reasons below. Rationale: [Resident #8] is doing well with Risperdal. His agitation is less frequent. It is my recommendation he continue his Risperdal." This rationale note was signed by the PA on 9/17/10 in the resident's attending physician's signature	F 428		

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F 428	Continued From page 31 block. Resident #8 had been on the medication for a year and there was no documentation in the medical record that the pharmacist had made a recommendation for gradual dose reductions or change in medication since the 9/14/10 report.	F 428		

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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: Lorna Bouse, BSW, Team Coordinator Arnold Rosling, RN Amy Beam, RN Survey Definitions: MDS = Minimum Data Set assessment RAI = Resident Assessment Instrument DON/DNS = Director of Nursing LN = Licensed Nurse CNA = Certified Nurse Aide ADL = Activities of Daily Living MAR = Medication Administration Record	C 000	**C-000 Initial Comments** "This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, **Idaho Falls Care and Rehabilitation Center** does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."	
C 125	02.100,03,c,ix 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: Refer to F241 as it is related to dignity and care for personal needs.	C 125	**C-125 see F241** **C-268 Dietary Service** ***Corrected actions for residents affected:*** No residents were identified as being affected by this deficiency. The kitchen received 100 percent in its review and certification. Previous dietary manager resigned and did not work out her notice	
C 268	02.107,01 DIETARY SERVICE 107. DIETARY SERVICE. 01. Dietary Supervision. A	C 268		

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FACILITY STANDARDS

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Interim Administrator — (X6) DATE: 08/09/11

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	135107		07/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO FALLS CARE & REHABILITATION CEN	3111 CHANNING WAY IDAHO FALLS, ID 83404

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C 268	Continued From page 1 qualified food service supervisor shall be designated by the administrator to be in charge of the dietary department. This person shall: This Rule is not met as evidenced by: Based on staff interview and personnel record review, it was determined the facility failed to have a qualified food service manager in charge of the kitchen at the time of the survey. Findings include: The facility's food service manager terminated her employment in June 2011. Employee #5 had been appointed the manager until the administrator was able to find a qualified replacement. Employee #5 had enrolled in the University of North Dakota Dietary Managers Course on 7/11/11 and is to complete it within the next 12 months. The administrator was informed on 7/12/11 at 10:00 a.m. The administrator indicated that the position was posted 6/17/11, he had received only one qualified applicant and was interviewing the individual on 7/13/11. The administrator advised the survey team, on 7/14/11, that he had made an offer to the person and was waiting for a response. No further information was provided.	C 268	***Identifying other residents having the potential to be affected, and what corrective action will be taken:*** The kitchen was inspected by the RD on 07/11/11 and no exceptions identified. ***Measures and systemic changes:*** Advertising was instituted 06/15/11and interviews were being conducted by the Administrator on 07/12/11 . The interim manager was enrolled in an accredited course for CDMs. ***Monitoring corrective action for sustained corrections:*** An accredited RD was hired for the manger's position by the Administrator on 07/14/11. The interim manager will continue to complete the CDM courses for potential in moving into a management position upon completion. This topic will be addressed in the performance improvement meeting for 3 months. **Date of Correction for this plan is : 8/15/11**	
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.	C 361	**C 361 See F 252**	

Bureau of Facility Standards

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 07/15/2011
NAME OF PROVIDER OR SUPPLIER: IDAHO FALLS CARE & REHABILITATION CEN'	STREET ADDRESS, CITY, STATE, ZIP CODE: 3111 CHANNING WAY IDAHO FALLS, ID 83404		

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C 361	Continued From page 2 This Rule is not met as evidenced by: Refer to F 252 as it relates to sanitary conditions.	C 361		
C 393	02.120,04,b b. A staff calling system shall be installed at each patient/resident bed and in each patient/resident toilet, bath and shower room. The staff call in the toilet, bath or shower room shall be an emergency call. All calls shall register at the staff station and shall actuate a visible signal in the corridor at the patient's/resident's door. The activating mechanism within the patient's/resident's sleeping room shall be so located as to be readily accessible to the patient/resident at all times. This Rule is not met as evidenced by: Refer to F 246 as it relates to availability of call lights for residents.	C 393	**C 393 See F 246**	
C 784	02.200,03,b b. Patient/resident needs shall be recognized by nursing staff and nursing services shall be provided to assure that each patient/resident receives care necessary to meet his total needs. Care shall include, but is not limited to: This Rule is not met as evidenced by: Referr to F 309 as it relates to resident receiving necessary care to meet the needs of residents.	C 784	**C 784 See F 309**	
C 790	02.200,03,b,vi	C 790	**C 790 See F 323**	

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C 790	Continued From page 3 vi. Protection from accident or injury; This Rule is not met as evidenced by: Refer to F323 as it is related to Care Planning for prevention of accidents and injuries.	C 790		
C 820	02.201,01,a a. Reviewing the medication profile for each individual patient at least every thirty (30) days. The attending physician shall be advised of drug therapy duplication, incompatibilities or contraindications. This Rule is not met as evidenced by: Refer to F428 as it is related to no recommendations for gradual dose reductions.	C 820	**C 820 See F 428**	
C 833	02.201,02,g g. No alteration or replacement of original prescription legend shall be allowed. This Rule is not met as evidenced by: Based on record review and staff interview, it was determined that original prescription legends were altered for 1 of 14 surveyed residents (#1). Findings included: 1. Resident #1 was admitted to the facility on 4/7/11 with diagnoses which included Alzheimer's disease, dementia, palliative care, coronary artery disease, and chronic pain. The resident's July 2011 physician's orders (recapitulation) included the following orders: * Ativan 0.5 mg (milligrams), 1 by mouth every 4 hours PRN (as needed) for anxiety. * Hydrocodone/APAP (hydrocodone with	C 833	**C-833 No Alteration or Replacement of Original Prescription Legend** ***Corrected actions for residents affected:*** MD reviewed chart for Resident # 1on 08/10/11 and signed /initialed progress notes stating the change made was by the MD. ***Identifying other residents having the potential to be affected, and what corrective action will be taken:*** An audit was conducted on 08/10/11 by the Director of Nursing to determine if any other altered scripts are in the charts and notify MD as needed.	

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C 833	Continued From page 4 acetaminophen) 5/500 mg 1 by mouth every 4 hours PRN for pain. The resident's medical record included 2 original prescription slips written on 4/7/11: * Ativan 0.5 mg (milligrams), 1 by mouth every 4-6 hours PRN (as needed) for anxiety. * Hydrocodone/APAP (hydrocodone with acetaminophen) 5/500 mg 1 by mouth every 4-6 hours PRN for pain. NOTE: Each of these hand written prescriptions was written in one type of pen with a thinner, lighter ink pattern and the same handwriting style. Each of the prescriptions was "Noted" by facility staff in a different type of pen with a thicker, darker ink pattern and different handwriting style. In the same ink and handwriting as the "Noted" documentation, each of the prescriptions had a slash mark crossing out the "-6" part of the "4-6 hours" portion of the original prescription legend. Each of these physician orders was then entered into the facility's physician orders (recapitulation) system as "every 4 hours" on 4/7/11. Neither of the changes to the prescriptions was initialed or dated. There were no clarification orders in the resident's medical record to document that someone had contacted the physician to seek clarification or to change the original prescription. The DON was advised of the findings on 7/13/11 at 12:00 PM. The DON stated that the physician crossed out the "-6" on the Ativan prescription, and "if they write a range order we always make them change it, so he did." The surveyor pointed out that the ink and handwriting were different between the originally written prescription, and the "Noted" and crossed out sections. The DON maintained that the physician had made the	C 833	***Measures and systemic changes:*** The Administrator provided the MD and PA a copy of this regulation and discussed the need not to alter scripts without initialing or dating, or just write new script. ***Monitoring corrective action for sustained corrections:*** Random audits to be conducted by Health Information Manager once a week for 4 weeks and monthly for 2 months for compliance with unaltered scripts; discrepancies will be reported to the Director of Nursing for physician follow up. The Director of Nursing is responsible for overall compliance. **Date of Correction for this plan is : 8/15/11** audits started 8/10/11 per tc c DON 8/17/11 at 11 AM ASR	

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C 833	Continued From page 5 change to the Ativan prescription, and made no comment about the hydrocodone/acetaminophen prescription. The DON and Administrator were advised of the findings on 7/13/11 at 4:00 PM. No further information was received from the facility.	C 833		
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: This Rule is not met as evidenced by: Refer to F 386 as it relates to physician and physician assistant not signing and dating progress notes	C 881	**C 881 See F 386**	