



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 6772

September 7, 2011

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

Provider #: 135107

Dear Mr. Parker:

On **August 23, 2011**, a Complaint Investigation 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. **WAIVER RENEWALS MAY BE REQUESTED ON THE PLAN OF CORRECTION. Please provide ONLY ONE completion date for each federal and state tag in column X5 (Complete Date), to signify when you allege that each tag will be back in compliance.** After each deficiency has been answered and dated, the administrator should sign both Statement of Deficiencies and Plan of Correction, Form CMS-2567 and State Form, in the spaces provided and return the originals to this office.

Roger A. Parker, Administrator
September 7, 2011
Page 2 of 3

Your Plan of Correction (PoC) for the deficiencies must be submitted by **September 20, 2011**. Failure to submit an acceptable PoC by **September 20, 2011**, may result in the imposition of civil monetary penalties by **October 11, 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*.

This agency is required to notify Centers for Medicare & Medicaid Services (CMS) Region X of the results of this survey. We are recommending that CMS impose the following remedy(ies):

Denial of payment for new admissions effective as soon as notice requirements can be met. [42 CFR §488.417(a)]

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,

Roger A. Parker, Administrator
September 7, 2011
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3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0036; phone number: (208) 334-6626; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. 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 **September 20, 2011**. If your request for informal dispute resolution is received after **September 20, 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 this office at (208) 334-6626.

Sincerely,



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

LT/dmj
Enclosures

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 C 08/23/2011
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NAME OF PROVIDER OR SUPPLIER IDAHO FALLS CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3111 CHANNING WAY IDAHO FALLS, ID 83404
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	INITIAL COMMENTS The following deficiencies were cited during two complaint investigations of your facility. The surveyors conducting the survey were: Marcia Key, BSN, WOCN, Team Coordinator Lea Stoltz, QMRP Survey Definitions: DON = Director of Nursing LN = Licensed Nurse CNA = Certified Nurse Aide	F 000	<p>“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.”</p> <p>F-353 Staffing Requirements</p> <p><i>Corrected actions for residents affected:</i> Resident #3 was re-assessed by Social Services on 09/09/11 to ensure that needs are being met and any concerns identified were addressed. Resident #5 was re-assessed by Social Services on 09/09/11 to ensure that needs are being met and any concerns identified were addressed.</p>	
F 353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.	F 353		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <i>Interim Administrator</i>	(X6) DATE <i>09-15-11</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

PRINTED: 09/07/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135107	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/23/2011
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F 353	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on a complaint from the public, observation, review of facility grievance reports and Resident Council minutes, staff and resident interviews, it was determined the facility failed to provide adequate staffing to meet the assessed needs of the residents. This had the potential to affect all residents. Findings include: A complaint from the public, submitted to the Bureau of Facility Standards on 8/18/11, alleged the facility did not have enough staff on duty on the weekends and on the night shift to care for the residents' needs. The complainant further alleged residents experienced long waits for call bells to be answered and this resulted in potential harm to the residents. An unannounced observation was conducted on 8/22/11 at 4:06 a.m. Upon arrival at the facility, there were 3 CNAs assigned to cover all 4 hallways, and 1 CNA assigned to provide 1-1 supervision with 1 resident. Two LNs were on duty. The census was reported to be 70 at the time of the observation. The CNA staffing assignment was the following: One CNA was assigned to perform 1:1 coverage for a resident in room #104. One CNA was assigned to hall 1 (17 residents) and resident rooms 307-310, (3 residents.) There were isolation carts outside resident room #s 112, 307, 308, and 310.	F 353	Resident #6 was re-assessed by Social Services on 09/09/11 to ensure that needs are being met and any concerns identified were addressed. Resident #1 was discharged from the center on 06/27/11. Resident #2 was discharged from the center on 06/13/11. Resident #4 was discharged from the center on 08/05/11. Identifying other residents having the potential to be affected, and what corrective action will be taken: An audit was completed by the Administrative Staff on or before 09/18/11 related to timeliness of call bell response and providing resident care. A review of the center's staffing schedule was completed by the Director of Nursing and the Administrator to identify staffing opportunities on 09/15/11. The review of the schedule included weekend and night coverage to provide care for the residents.		

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F 353	<p>Continued From page 2</p> <p>One CNA was assigned to hall 2 (20 residents) and resident rooms 301-306, (4 residents.) There were no residents on isolation precautions.</p> <p>One CNA was assigned to hall 4 (21 residents) and resident rooms 311-315, (4 residents.) There was one isolation cart outside resident room #415.</p> <p>According to information provided by the facility on the levels of assistance necessary to meet the needs of the residents, including transfer/mobility and bed mobility, the following levels were documented:</p> <p>14 residents required 2 person staff assist for bed mobility and 2 person mechanical lift use for transfers.</p> <p>10 residents required 2 person staff assist for bed mobility and transfers.</p> <p>Note: The need for 2 person staff assist for bed mobility would result in a need for 2 person staff assist to reposition for the protection of skin integrity and changing incontinent briefs if used.</p> <p>42 residents required 1 person assist for bed mobility and transfers.</p> <p>4 residents were independent with mobility and transfers.</p> <p>With 1 CNA assigned to do 1-1 supervision with a resident at all times on all shifts, 3 CNAs were left responsible to meet the needs of 65 of the 70 residents requiring staff assistance. It was unclear how resident care was provided with that</p>	F 353	<p><i>Measures and systemic changes:</i></p> <p>An open house was conducted on 09/06/11 to fill open positions. Contact was made with Quality Medical Staffing Agency on 09/14/11 by the Administrator related to establishing a contract for outside staffing. The Director of Nursing Services and Staff Development Coordinator were re-educated on 09/15/11 by the Administrator related to the daily staffing requirements.</p> <p><i>Monitoring corrective action for sustained corrections:</i></p> <p>An audit will be completed by the Department Managers weekly for 1 month and monthly for 2 months to ensure resident care concerns are addressed. The Administrator and DNS will review staffing schedules weekly for 4 weeks and monthly for 2 months to ensure staffing is maintained at a level to meet resident's needs. A report will be submitted to the Performance Improvement Committee monthly for 3 months.</p> <p>The Director of Nursing is responsible for over all compliance.</p>	

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F 353	<p>Continued From page 3</p> <p>number of staff, and also unclear how coverage was provided for staff breaks and meals.</p> <p>The survey team interviewed employees at random times during the survey. In order to keep the interview information anonymous, the employees were assigned random identifiers which did not correspond to the order each employee was interviewed. Each employee's title/role was excluded from this report. The date/time of each interview was also excluded from this report, to ensure anonymity.</p> <p>Employee (D) stated the facility has been short-staffed for several months. If a resident required two person transfer, the staff member must put the resident's call light on and wait for a second staff member to assist with the cares. The staff member also stated he/she was certain all the resident cares did not get performed, and staff had to prioritize the work load. The staff member could not give any specific dates/times that cares were not performed nor names of residents involved.</p> <p>Employee (M) stated the facility has been short-staffed for "awhile." At the beginning of each shift, the staff members get report from the previous staff, then staff make sure residents who are incontinent of bowel/bladder were changed. Then the staff attempt to "check and change" residents during the every two hour rounds. The staff member stated at times the staff members might perform incontinent cares for residents without a second staff member available to assist. This could be difficult if the resident was not able to assist to turn him/herself. The staff member could not recall if any</p>	F 353	<u>Date of Compliance : 9/19/11</u>		

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F 353	<p>Continued From page 4</p> <p>residents' perineal areas had become reddened or had resultant skin breakdown due to not getting changed after incontinent episodes.</p> <p>Employee (M) also stated the staff members did not get meal breaks because there was no staff available to cover the assignments. "We are too short-handed to leave."</p> <p>Employee (M) stated there were several residents who were in isolation precautions which takes extra time when caring for these residents.</p> <p>Employee (P) declined to speak with the survey team.</p> <p>Random residents were interviewed during the survey. When asked about the availability of staff to meet their needs on nights and weekends, they responded with the following comments:</p> <p>* "They need more people. I had an accident because I waited 45 minutes for help [to use the bathroom]. Some young kid came in and told me that 3 people called in." I'm paying a lot of money to live here and you should get care. The LNs take turns with bedpans because of call-ins, I listen to it every day. They say, "We're sorry."</p> <p>* "Sometimes they are on the other hall and you have to wait. I wear attends and have to be changed several times at night."</p> <p>* "Sometimes at night it takes a long time to answer the call light. It's worse at night recently."</p> <p>* "Yes, they have problems getting in here because there is not enough staff."</p>	F 353			

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F 353	Continued From page 5 * "I wait a long time for them to [perform specific treatment]." Facility Grievance Reports from 6/1/11 - 8/17/11 were reviewed and revealed the following: Resident #1 reported another resident wandered into her room at 11:00 p.m. and scared her. Resident #2's family reported long waits for CNAs to care for a resident. Resident #3 reported staff took a long time to answer the call light. Resident #4's family member received a telephone call from a resident reporting the call light was not available. When family called the facility to report the issue, there was no answer to the telephone call for 90 minutes. Resident #5 complained about being left on the bedpan for 45 minutes, and had to call the facility telephone number to receive help. Resident #3 complained night shift staff were not checking on [resident] because they were inadequately staffed. Resident #6 complained about waiting 30 minutes for the call light to be answered, and had a toileting accident. Staff reportedly told the resident they were short staffed. A Three-Week Nursing [staffing] Schedule was reviewed for the weeks of 7/31/11, 8/17/11 and 8/14/11. The average number of residents in the	F 353		

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F 353	<p>Continued From page 6</p> <p>facility for the time period was 72.2. The number of nursing staff hours worked per resident per day was calculated, and on 8/21/11 the total was 2.1. The form documented 89.75 total CNA hours for the 24 hour period, and included handwritten information "+ [plus] DON for 16 hrs [hours] as an Aide." The DON had worked as the 1-1 staff for 1 resident for 16 hours that day, as confirmed during interview on 8/23/11 at 8:25 a.m. with the acting Administrator, Corporate Consultant and DON.</p> <p>In addition, the initial Three-Week Nursing Schedule submitted on 8/22/11 for surveyor review was missing information for 7 of the requested days. A revised schedule was provided on 8/23/11 which was completed, however, when totals were compared to the payroll documentation for the dates reviewed, it showed discrepancies in the total hours recorded. For many of the discrepancies, the errors were in adding, which resulted in conflicting totals of hours worked. It was not possible to determine actual/accurate staffing levels from the submitted Three-Week Nursing Schedules submitted for review.</p> <p>The acting Administrator, Corporate Consultant and DON were informed of the issues on 8/23/11 at 11:00 a.m. No further information was provided by the facility.</p>	F 353		

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 08/23/2011
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C 000	<p>16.03.02 INITIAL COMMENTS</p> <p>The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2.</p> <p>The following deficiencies were cited during two complaint investigations of your facility.</p> <p>The surveyors conducting the survey were:</p> <p>Marcia Key, BSN, WOCN, Team Coordinator Lea Stoltz, QMRP</p> <p>Survey Definitions: DON = Director of Nursing LN = Licensed Nurse CNA = Certified Nurse Aide</p>	C 000	<p>“This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Idaho Falls Care 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.”</p>	
C 768	<p>02.200,02,d,ii</p> <p>ii. Skilled Nursing Facilities with a census of sixty (60) or more patients/residents shall provide 2.4 hours per patient/resident per day. Hours shall not include the Director of Nursing Services or supervising nurse.</p> <p>This Rule is not met as evidenced by: Based on record review and staff interview it was determined the facility did not meet the 2.4 nursing staff ratio for 1 of 22 days reviewed. This had the potential to affect all residents living at the facility. The findings include:</p> <p>A Three-Week Nursing [staffing] Schedule was reviewed for the weeks of 7/31/11, 8/17/11 and 8/14/11. The average number of residents in the facility for the time period was 72.2. The number of nursing staff hours worked per resident per day</p>	C 768	<p>C 768 02.200,02,d,ii Staffing</p> <p>See F 353</p>	<p style="text-align: right; color: purple; font-weight: bold;">RECEIVED SEP 16 2011 FACILITY STANDARDS</p>

Bureau of Facility Standards	TITLE	(X6) DATE
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	<i>Interim Administrator</i>	<i>09-15-11</i>

Bureau of Facility Standards

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C 768	Continued From page 1 was calculated, and on 8/21/11 the total was 2.1. The form documented 89.75 total CNA hours for the 24 hour period, and included hand written information "+ [plus] DON for 16 hrs [hours] as an Aide." The DON had worked as the 1-1 staff for 1 resident for 16 hours that day, as confirmed during interview on 8/23/11 at 8:25 a.m. with the acting Administrator, Corporate Consultant and DON. For additional findings related to inadequate staffing, please refer to F353.	C 768			



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
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FAX 208-364-1888

September 14, 2011

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

Provider #: 135107

Dear Mr. Parker:

On **August 23, 2011**, a Complaint Investigation survey was conducted at Idaho Falls Care & Rehabilitation Center. Marcia Key, R.N. and Lea Stoltz, Q.M.R.P. conducted the complaint investigation. A total of 31 survey hours were required to investigate this and an additional complaint.

Interviews were conducted with the acting Administrator, corporate consultant, Director of Nursing, random direct care staff and ten (10) residents.

The following records were reviewed:

- Grievance reports from June 1, through August 17, 2011;
- Resident Council meeting minutes for June, July and August 2011;
- Nursing staff payroll records for July 31 through August 21, 2011;
- Incident/Accident reports from June 1 through August 17, 2011;
- Current posted staffing level documentation; and
- Three-Week Nursing Schedule for July 31 through August 21, 2011.

Observations of residents care, call light response and staffing levels were conducted on August 22, 2011, from 4:06 a.m. through 3:30 p.m. Further observations were conducted on August 23, 2011, from 7:00 a.m. through 3:30 p.m.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00005192

Roger A. Parker, Administrator
September 14, 2011
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ALLEGATION #1:

The complainant stated the facility failed to provide adequate staffing on the night shift and on the weekends, which resulted in residents waiting long periods for call lights to be answered.

In addition, the complainant stated that due to insufficient staffing, an unidentified resident crawled out of bed and to the bathroom because the light was not answered. The complainant did not know if the resident sustained an injury. A second unidentified resident developed abdominal pain, thought to be due to a kinked and twisted Foley catheter tubing. The pain was relieved once the tubing was straightened. Both these incidents happened due to staff rushing to do their work.

FINDINGS:

An unannounced observation was conducted on August 22, 2011 at 4:06 a.m. Upon arrival at the facility, there were three CNAs (certified nurse aides) assigned to cover all four hallways and one CNA assigned to provide 1-1 supervision with one resident. Two LNs (licensed nurses) were on duty. The census was reported to be 70 at the time of the observation.

Based on further investigation, including resident and staff interviews, grievance report review and observations it was determined the facility failed to provide adequate staffing to meet residents needs. The facility was cited for the deficient practice at F353.

CONCLUSIONS:

Substantiated. Federal and State deficiencies related to the allegation are cited.

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

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

Sincerely,

A handwritten signature in black ink that reads "LORENE KAYSER". The 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

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September 14, 2011

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

Provider #: 135107

Dear Mr. Parker:

On **August 23, 2011**, a Complaint Investigation survey was conducted at Idaho Falls Care & Rehabilitation Center. Marcia Key, R.N. and Lea Stoltz, Q.M.R.P. conducted the complaint investigation. A total of 31 survey hours were required to investigate this and an additional complaint.

Interviews were conducted with the acting Administrator, corporate consultant, Director of Nursing, the facility's physician assistant/physician extender, occupational therapist, speech therapist, random direct care staff and ten (10) residents.

The following records were reviewed:

- The identified resident's closed record;
- Grievance reports from June 1 through August 17, 2011;
- Resident Council meeting minutes for June through August 2011;
- Nursing staff payroll records for July 31 through August 21, 2011;
- Incident/Accident reports from June 1 through August 17, 2011;
- Current posted staffing level documentation;
- Three-Week Nursing Schedule from July 31 through August 21, 2011; and
- The facility's most recent Recertification and State Licensure survey results of July 15, 2011.

Observations of residents care, call light response and staffing levels were conducted on August 22, 2011, from 4:06 a.m. through 3:30 p.m. Further observations were conducted on August 23, 2011, from 7:00 a.m. through 3:30 p.m.

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The complaint allegations, findings and conclusions are as follows:

Complaint #ID00005178

ALLEGATION #1:

The complainant stated an identified resident was taken to therapy immediately after breakfast rather than allowing the resident to rest after meals. The therapy staff also took the resident to therapy before receiving any hygiene or incontinence care.

The complainant also stated an unidentified occupational therapist forced the resident to drink a glass of water immediately after an exercise. The resident vomited and continued to vomit while in his room.

FINDINGS:

The identified resident's record documented the resident was admitted to the facility with a history of gastrointestinal problems, including difficulty swallowing at times. Staff addressed the resident's medical issues.

The occupational therapist stated staff made attempts to coordinate the therapy sessions; however, multiple family members had differing opinions of when the sessions should be performed. The therapist stated a family member did not want the resident to attend therapy and would decline the sessions. The occupational therapist stated the resident did have problems with "dry heaves" but this was unrelated to the exercises or offering the resident fluids.

The speech therapist stated she had several conversations with a family member of the identified resident. At times, the family member declined to allow the speech therapist to observe and work with the resident while he was in his room or in the therapy department.

The speech therapist stated the resident had no swallowing problems but had problems with the food after he swallowed.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The complainant stated the therapy staff did not sanitize the equipment between resident uses.

FINDINGS:

Facilities are responsible to sanitize equipment as necessary if body fluids come in contact with equipment or after residents who require certain types of isolation precautions use the equipment.

It is not an expectation that each time a resident touches a piece of equipment or furniture that it must be sanitized, unless the item is contaminated as described above.

During observations by the survey team, there were no observations of any body fluids spilled and left unattended by staff that could potentially come in contact with residents, visitors or staff.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The complainant stated a visitor found the resident sitting on the toilet and the resident had been left there for over an hour.

FINDINGS:

Although this allegation could not be verified, the facility was cited at F353 for failure to provide adequate staffing to meet the assessed needs of the residents. This finding was based on the second complaint investigated during the survey and based on observation, staff and resident interviews and review of facility's grievance reports and Resident Council minutes.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

The complainant stated an identified resident had been left in his wheelchair and when he attempted to get back to bed by himself, he fell. Visitors found him on the floor.

FINDINGS:

The identified resident's record contained no documented evidence that the resident sustained a fall while in the facility. Review of the facility's Incident/Accident reports found no investigation report regarding the resident.

The Director of Nursing stated she was unaware of any falls by the resident. She also stated that she

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had many discussions with the resident's family members and if a visitor or family member had witnessed the resident on the floor, at least one member of the family would have told her.

During the facility's most recent Recertification and State Licensure survey of July 15, 2011, the facility was cited at F323 for its failure 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, who was a high fall risk and had actual falls in the facility.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #5:

The complainant stated an identified resident ate in his room, served meals late; the food was cold and not the correct proportions.

FINDINGS:

The residents who were interviewed voiced no concerns about the food served in the facility.

During the most recent Recertification and State Licensure survey of July 15, 2011, residents were observed during meal times and interviewed regarding the food. Menus were reviewed and observations made of the kitchen at various times during the survey, including observations of a meal tray line. The facility was not cited for any deficient practice related to food service.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #6:

The complainant stated an identified resident did not get his evening medications on time.

FINDINGS:

The identified resident's physician medication orders and the Medication Administration Record revealed that only one medication was specifically ordered before meals and at bedtime.

The Medication Administration Record documented the medication given as directed.

There were no other medications that were required to be given at specified times of the day. Medications were directed by the physician to be administered daily, twice daily, three times daily or

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on an as needed basis.

The Resident Council minutes and grievances did not identify any concerns about medication administration and residents interviewed voiced no concerns.

During the most recent Recertification and State Licensure survey of July 15, 2011, the facility was cited at F328 for not ensuring physician's orders for administration of oxygen were implemented consistently for a resident who received treatment with oxygen.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #7:

The complainant stated an identified resident was kept on Lasix too long, became dehydrated and "lost a lot of weight." The resident's condition deteriorated and on June 10, 2011, the resident's family member called an ambulance and took the resident to the local hospital, where the resident stayed for three days due to dehydration and weight loss.

On June 25, 2011, the resident again required hospitalization for dehydration and feeding tube placement.

FINDINGS:

The identified resident's record included the hospital records from May 22, 2011, which documented the resident had a several month history of abdominal pain that had required hospitalization on May 8, 2011, and it was determined at that time he was "a poor surgical candidate."

The May 22, 2011, hospital record documented the resident appeared "somewhat somnolent... and somewhat cachectic..." (generalized weakness, malnourished, emaciated.) The resident was also constipated. He had abnormal blood values.

The June 10, 2011, hospital record documented in part: "...Over the last month, he has had intermittent problems ...and has been in and out of the hospital... on at least 2 separate occasions. He has not been felt to be a good surgical candidate because of his debility as well as multiple medical conditions... His laboratory data was fairly unremarkable, other than some mild dehydration... He has some chronic fluid overload that is treated with diuretics..."

Review of the resident's laboratory data from May through June 24, 2011, revealed chronic abnormal lab values.

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The resident's facility record contained documented evidence the resident was monitored closely by the nursing staff. The physician and/or extender were kept informed of the resident's condition. Treatments were initiated as indicated, including fluid restriction and intravenous therapy.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

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

Sincerely,

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

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

LKK/dmj