



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
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PHONE 208-334-6626
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October 3, 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 your facility. You have alleged that the deficiencies cited on that survey will be corrected. We have accepted your Plan of Correction.

On September 30, 2011, an on-site follow-up revisit of your facility and a Complaint Investigation was conducted to verify correction of deficiencies noted during the Recertification and State Licensure survey of July 15, 2011, and Complaint Investigation survey of August 23, 2011. Idaho Falls Care & Rehabilitation Center was found to be in substantial compliance with health care requirements as of **August 15, 2011**, for the deficiencies cited during the Recertification and State Licensure survey of July 15, 2011, and was found to be in substantial compliance with health care requirements as of **September 19, 2011**, for the deficiencies cited during the Complaint Investigation survey of **August 23, 2011**.

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

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

Sincerely,


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

LKK/dmj
Enclosures



IDAHO DEPARTMENT OF
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October 21, 2011

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

Provider #: 135107

Dear Mr. Parker:

On **September 30, 2011**, a Complaint Investigation survey was conducted at Idaho Falls Care & Rehabilitation Center. Marcia Key, R.N. and Madeleine Parmley, R.N. conducted the complaint investigation. A total of 40 survey hours were required to complete this investigation and two follow-up surveys of July 15, 2011 and August 23, 2011.

The following documents were reviewed:

- Three abuse and neglect investigation reports involving the identified resident, completed by the facility and sent to the Bureau of Facility Standards in 2011.
- The identified resident's records.
- Resident council minutes, grievances and abuse investigations from August 15, through September 27, 2011.
- In-service presentation by the local ombudsman for the facility staff dated September 21, 2011.
- The facility's most recent annual Recertification and State Licensure survey of July 15, 2011, and Complaint Investigation of August 23, 2011.

The following individuals were interviewed:

Local ombudsman, Administrator, Director of Nursing (DoN,) licensed social worker (LSW,) one (1) licensed nurse (LN) and the treating physician.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00005236

ALLEGATION #1:

The complainant stated staff are abusing an identified resident. They are mean and vicious to the resident. They pinched her, manhandled her, grabbed her firmly and restrained her legs with their hands when turning her.

Staff does not listen to the resident when she says her incontinence briefs are put on too tight.

The complainant stated the identified resident has reported these abuses to the Administrator, ombudsman and her Power of Attorney (POA). The complainant stated the resident's complaints are not taken seriously.

FINDINGS:

The facility investigated three separate allegations of abuse by staff towards the identified resident and found no evidence of abuse. The Bureau of Facility Standards reviewed these investigations. No further action by the facility was required.

In addition, the identified resident was part of the Phase 1 sample for the Recertification & State Licensure survey of July 15, 2011. Among other care areas, she was reviewed for abuse. The survey team ruled out deficient practices in this area. The resident's care plan was very specific regarding behaviors including a "tendency to accuse people of doing things that don't happen the way she says and she exaggerates."

The Administrator provided a summary of a care conference held at the facility on August 30, 2011. In attendance were the identified resident, Administrator, DoN, social services director, the ombudsman and her assistant. The entry documented in part:

"We discussed (resident's) care and her need to be compliant and what options were available. We also disused her behavior toward staff and the need for her to be more polite. (Resident) agreed to try to be more polite to staff and participate in her care..."

The local ombudsman has been actively involved since at least May 13, 2011, in attempts to resolve grievances involving the identified resident. On September 21, 2011, the ombudsman presented an in-service for the facility staff. There were 44 staff signatures on the "sign-in" sheets. The presentation was titled, "Validation & dealing with difficult behaviors." The handout material was titled, "Improving Your Communication Skills, Every Day Approaches to Prevent Difficult Behaviors."

Roger A. Parker, Administrator
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CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The complainant stated staff members on every shift do not answer an identified resident's call lights for more than 30 minutes. This has been occurring since the resident was admitted to the facility.

FINDINGS:

During the complaint survey of August 23, 2011, it was determined the facility failed to provide adequate staffing to meet the assessed needs of the residents. This included residents' concerns about call lights not being answered in a timely manner. The facility was cited at F353 for this failed practice.

During the September 30, 2011, survey the facility was found to be in compliance for this citation after the survey team reviewed the facility's plan of correction, audits, grievances and Resident Council minutes.

The identified resident's record contained entries that the resident complained that staff was not answering her call lights for at least up to 25 minutes; however, LN staff observed the staff answering the call lights within five (5) minutes.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The complainant stated an identified resident is incontinent because staff does not assist her to toilet in a timely manner. When the resident was admitted to a local hospital for vein surgery, she was diagnosed with chronic urinary tract infection (UTI,) which was not being treated by the facility.

FINDINGS:

Hospital records dated May 4, 2011, documented that the identified resident was admitted to the hospital from home with an indwelling Foley catheter. The Admission History and Physical Examination report documented in part: "...Possible urinary tract infection - This may be catheter related, as the patient presented to the hospital with a Foley catheter, but she is asymptomatic and; therefore, we will continue to follow for right now..."

The resident was admitted to the facility on May 7, 2011, with the Foley catheter in place. The catheter was discontinued on May 10, 2011.

Nurse's notes dated May 14, 2011, documented "...Resident determined to have indwelling catheter as 'incontinence is humiliating.'"

A social service's note dated May 17, documented "(Resident) has been purposefully soiling herself D/T (due to) she wants her catheter back per her statement to staff..."

Nurse's notes dated May 18, 2011, documented "...Resisting care of changing BMs and urine. She insists she must have indwelling catheter..."

May 22, 2011, "...Incontinent B & B (bowel and bladder) refuses to wear attends..."

On May 23, 2011, the resident was started on an antibiotic for a urinary tract infection.

Nurse's notes dated May 26, 2011, documented "Answered call light. Repositioned in bed. Resident stated she had wet but refused cares."

On June 18, 2011, the resident was started on an antibiotic for a urinary tract infection.

On June 21, 2011, the physician assistant documented "...She also has been on Cipro due to a presumed urinary tract infection... Unfortunately she is incontinent and was unable to get a clean catch on her..."

The remainder of the resident's record through September 19, 2011, did not contain any documented evidence that the resident had further urinary tract infections. When the resident returned to the facility on September 21, 2011, following the brief hospitalization there was no order for an antibiotic secondary to a urinary tract infection.

The identified resident's record documented attempts by staff to assist the resident in all her personal care needs in a timely manner. There were multiple refusals by the resident to allow the staff to provide the personal cares.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

The complainant stated staff members place dirty laundry on the floor. When it is picked up no one cleans the floor.

FINDINGS:

During the annual Recertification & State Licensure survey of July 15, 2011, the facility was cited at F252 for failure to ensure that urine odor outside and inside a resident's room was eliminated in a timely manner.

During the Complaint Investigation of August 23, 2011, the survey team found no environment or housekeeping concerns.

During the Complaint Investigation of September 30, 2011, the survey team found no environment or housekeeping concerns.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #5:

The complainant stated an identified resident developed a pressure ulcer on her foot after her admission to the facility in April 2011. Staff did not position or turn the resident.

The resident developed MRSA (Methicillin-resistant Staphylococcus Aureus) in her foot ulcer after an unidentified nurse cut off skin on the ulcer with scissors from her pocket and then placed the dirty scissors back in her pocket.

FINDINGS:

During the July 15, 2011, annual Recertification & State Licensure survey, the identified resident was selected as part of the phase one resident sample review. Among other care areas, she was reviewed for pressure ulcers and wound infection. The survey team ruled out deficient practices in this area. The pressure ulcer was determined to be unavoidable. It was not determined that the wound infection was due to any staff deficient practice.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #6:

The complainant stated an identified resident received insulin before her hyperbaric treatments even though the staff at the treatment center said not to give the resident the insulin prior to treatments because the resident could develop insulin shock.

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The complainant also stated an identified resident was to receive eardrops; however, on the morning of September 22, 2011, an unidentified staff member entered the resident's room and said he was going to administer eye drops to the resident. This occurred twice by the same staff member.

FINDINGS:

The identified resident's record contained an order dated July 26, 2011, written by a physician's assistant at a local hyperbaric wound care center. The order directed, "Hold AM insulin 07-27-2011." The order did not direct staff at the facility to continue to hold the resident's morning insulin on future dates.

There was no order from the resident's treating physician to alter the times and dosage of the resident's morning insulin.

The LN who worked with the resident on September 22, 2011, stated that he had mistakenly said the word "eye" instead of "ear" drops but he knew the medication was ordered for the resident's ear. During the survey team's interview with the LN he also mistakenly said "eye" drops to the survey team, then quickly stated, "See, I'm even saying it wrong to you, but I knew it was ear drops." The LN appeared confident in his statement to the survey team.

There was no indication the LN was not aware that he was to administer eardrops rather than eye drops to the resident.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #7:

The complainant stated an identified resident missed a physician's appointment in August 2011 because facility staff forgot to take her.

FINDINGS:

The LN stated a staff from an off-site medical clinic arranged for the medical consult appointment. The facility staff and van driver were not informed of the appointment by the medical clinic staff. Once the facility's staff was informed of the missed appointment, the van driver who arranges the medical appointments was able to schedule an appointment for the next day. The resident was taken to this appointment.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #8:

The complainant stated and that on approximately September 20, 2011, an identified resident's blood sugar went down to 100 and she requested food but the staff did not give her any food or fluid. The blood sugar went down to 60, then 39 before staff intervened.

FINDINGS:

A Change of Condition Documentation form dated September 17, 2011, contained the following:

"Approx 1500 (Approximately 3:00 p.m.) Resident stated she did not feel well and if staff would (check) her BG (Blood Glucose). BG was 60. Staff gave resident orange juice (with) sugar. 1515 (3:15 p.m.) BG was 46. Glucose PO (by mouth) was given... BG was 46. Staff gave IM (IM Glucagon). Resident was very drowsy and difficult to arouse... (After) about 15 min (minutes) resident's BG was 55. After 30 min BG was 119. 1800 (6:00 p.m.) BG was 286... (name of physician assistant) was updated..."

The identified resident's nurses notes contained documented evidence the staff members intervened per physician's standing orders after the resident's blood sugar level was low.

The LN who wrote the nurse's note attested to the accuracy of the entry.

The resident's record contained numerous documentation of non-compliance on the part of the resident in regards to her diabetes management.

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,



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