



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

April 15, 2013

James H. Hayes, Administrator
River Ridge Care & Rehabilitation Center
640 Filer Avenue West
Twin Falls, ID 83301-4533

Provider #: 135106

Dear Mr. Hayes:

On April 1, 2013, an on-site follow-up revisit of your facility and Complaint Investigation survey was conducted to verify correction of deficiencies noted during the Recertification and State Licensure survey of February 15, 2013. River Ridge Care & Rehabilitation Center was found to be in substantial compliance with health care requirements as of **March 20, 2013**.

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

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

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

LKK/dmj
Enclosures



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April 18, 2013

James H. Hayes, Administrator
River Ridge Care & Rehabilitation Center
640 Filer Avenue West
Twin Falls, ID 83301-4533

Provider #: 135106

Dear Mr. Hayes:

On **April 1, 2013**, a Complaint Investigation survey was conducted at River Ridge Care & Rehabilitation Center. Arnold Rosling, R.N., Q.M.R.P. and Lorene Kayser, L.S.W., Q.M.R.P. conducted the complaint investigation.

During the complaint investigation, that was conducted with an on-site follow-up revisit to the Recertification and State Licensure survey of February 15, 2013, the records of six residents including that of the identified resident were reviewed. Interviews were conducted with a variety of staff and residents, and a tour of the facility was conducted upon entrance for the investigation.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00005964

ALLEGATION #1:

The complainant stated the identified resident was first admitted to the facility around Thanksgiving time in 2012 for rehabilitation due to surgery on his right leg.

The resident was discharged home and was only home for four hours when he fell and broke his left hip. The resident was admitted to a local hospital for two days.

James H. Hayes, Administrator

April 18, 2013

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The resident went back to the facility, and toward the end of January or first part of February 2013, he developed pneumonia and went back to the hospital. When he returned to the facility, a family member spoke to the resident by phone every day. The resident "never sounded right"; he was congested and had a "horrible" cough.

On March 16, 2013, he sounded really bad, so the family member called the facility and spoke to an identified nurse. When told that the resident did not sound good, the nurse seemed upset and said the resident was fine, he just had a little diarrhea. When asked what the resident's oxygen level was the nurse said it was 92 %. The family member reminded the nurse that the resident recently had pneumonia and his breathing had "never sounded good since he had pneumonia." The nurse said the doctor was not in as it was Saturday, and they could only call the doctor on call. The family member was concerned that the resident would get worse if they waited until Monday. The nurse said, "If he gets worse we will ship him back to ER (the emergency room)." Less than an hour later, a second family member called to say that their brother was in the hospital and had been told that the resident was, "close to dying." The caller was sure if the first family member had not called the facility, the resident would have died.

FINDINGS:

The identified resident was initially admitted to the facility on December 15, 2012, for post-operative care for right Femoral and Popliteal bypass surgery. The resident had three subsequent admissions since that time. The resident has severe Chronic Obstructive Pulmonary Disease (COPD).

The resident was steadily improving initially until January 16, 2013, when found unresponsive with a pulse oxygen of 79%. The resident was transported to the hospital. The resident was diagnosed with, "Sepsis, Urinary tract infection, Pneumonia, aspiration versus health care associated, hypoxia and mild to moderate respiratory distress." The resident was admitted at that time.

The resident was readmitted to the facility on January 20, 2013, to continue care for the bypass surgery and to strengthen him from the hospitalization. The resident's course at the facility was uneventful. He made progress to a point that he was discharged home on February 11, 2013, at 11:30 a.m. and was to have home health services.

The resident fell at home on February 11, 2013, at 10:30 p.m. and fractured the left hip. The hip was repaired at the hospital. The resident was also having some shortness of breath from his COPD. The resident was readmitted to the facility for aftercare for the fractured hip along with the COPD.

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On March 16, 2013, at 10:40 a.m. a nursing note documented "Lungs (with) expiratory wheezes. (Resident) coughing up greenish sputum. States he thinks he is getting pneumonia again. Wants to go to the ER for evaluation and treatment..." At 11:15 a.m., the resident was transferred to the ER and was eventually admitted to the hospital. The Admission History and Physical documented the resident had, "1. Bibasilar pneumonia, 2. Probable aspiration, 3. This could be pulmonary hemorrhage given the blood he is coughing up and that could account for some of the CT appearance possibly, 4. Urinary tract infection, 5. Status post fractured femur, 6. Chronic obstructive pulmonary disease with exacerbation at this point and 7. Peripheral vascular disease post endarterectomy, etc." The cultures that were taken of the sputum and urine grew Klebsiella bacteria and the resident was started on doxycycline.

The resident was readmitted to the facility on March 21, 2013. The resident was interviewed on April 1, 2013, at 1:00 p.m. and indicated that he was doing better, and the facility was caring for his needs. He was on his way to see his physician. The resident had audible wheezing when interviewed, and he indicated that he had that all the time but was feeling better.

In conclusion, the resident has a history of COPD and frequent pneumonia. Nursing staff responded to the resident's request to go to the ER, and he was transported in a timely manner. The Admission History and Physical documented the resident and family said he was having blood in his sputum. The nursing documentation indicated the sputum was green, which is consistent with a bacterial infection such as Klebsiella. In addition, the physician order was for the oxygen saturation to be greater than 90 %.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The complainant stated the resident has lost 40 pounds since he was admitted to the facility. The resident complained the food was inedible; even though the resident was a good eater prior to that.

FINDINGS:

At the time of his first admission on December 15, 2012, right after he had right Femoral and Popliteal bypass surgery, the identified resident weighed 181 pounds and he had a body mass index (BMI) of 25.9. The resident was placed on a house controlled carbohydrate (HCC) regular diet.

The resident was admitted to the hospital on January 16, 2013, with pneumonia and readmitted to

James H. Hayes, Administrator
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the facility on January 20, 2013. The resident's weight at this admission was 164.2 pounds with a BMI of 23.6. The dietitian documented on her notes that the resident's plan was to have "supplemental nutrition program three times a day with meals."

The resident was discharged to home on February 11, 2013. The resident fell the same day and was eventually readmitted to the facility on February 16, 2013. The resident's weight on this admission was 142.8 pounds with a BMI of 20.4. The dietitian documented her plan was to, "provide increased Kcal/protein snacks twice a day" and to "implement supplemental nutrition program with meals." On March 3, 2013, the resident's weight had increased to 149 pounds.

On March 16, 2013, the resident was readmitted to the hospital and he returned on March 21, 2013. The resident's weight on this admission was 147.04 pounds and he had a BMI of 21.1. The dietitian's recommendations were for the resident to have a, "supplemental nutrition program three times a day" and to have "snacks twice a day."

The resident did sustain a weight loss since the time of his admission; however, due to multiple admissions and discharge, the bouts with pneumonia and exacerbation of his COPD symptoms, it could be determined that the facility was responsible for the weight loss. The dietitian implemented a variety of interventions to prevent weight loss. The resident had documented intakes ranging from 75% when he was well to 0 to 25% just prior to hospitalizations. The resident was seen and interviewed on April 1, 2013, at 1:00 p.m. and appeared much improved and stated he was content with the care he was receiving.

At the time of the Recertification and State Licensure survey, there were no resident complaints or citations related to the quality of the food or weight loss.

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