



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: 7012 1010 0002 0836 1710

April 23, 2014

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

FILE COPY

Provider #: 135106

Dear Mr. Hayes:

On **April 11, 2014**, a Recertification, Complaint Investigation and State Licensure survey was conducted at River Ridge Center by the Idaho Department of Health and Welfare, Division of Licensing and Certification, 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 3). **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 the Form

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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 **May 6, 2014**. Failure to submit an acceptable PoC by **May 6, 2014**, may result in the imposition of civil monetary penalties by **May 27, 2014**.

The components of a Plan of Correction, as required by CMS include:

- 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 in place or what systemic change will you make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice does not recur, i.e., what quality assurance program will be put into place. This monitoring will be reviewed at the follow-up survey as part of the process to verify that the facility has corrected the deficient practice. Monitoring must be documented and retained for the follow-up survey. In your Plan of Correction, please be sure to include:
 - a. Specify by job title who will do the monitoring.
 - * It is important that the individual doing the monitoring have the appropriate experience and qualifications for the task.
 - * The monitoring cannot be completed by the individual(s) whose work is under review.
 - b. Frequency of the monitoring; i.e., weekly x 4, then q 2 weeks x 4, then monthly x 3.
 - * A plan for "random" audits will not be accepted.
 - * Initial audits must be more frequent than monthly to meet the requirement for the follow-up.
 - c. Start date of the audits;
- Include dates when corrective action will be completed in column (X5).

If the facility has not been given an opportunity to correct, the facility must determine the date compliance will be achieved. If CMS has issued a letter giving notice of intent to implement a denial of payment for new Medicare/Medicaid admissions, consider the effective date of the remedy when determining your target date for achieving compliance.

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- The administrator must sign and date the first page of both the federal survey report, Form CMS-2567 and the state licensure survey report, State Form.

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 **May 16, 2014 (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 **May 16, 2014**. A change in the seriousness of the deficiencies on **May 16, 2014**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **May 16, 2014** includes the following:

Denial of payment for new admissions effective **July 11, 2014**. [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 **October 11, 2014**, 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 Lorene Kayser, L.S.W., Q.M.R.P. or David Scott, R.N., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; 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 **April 11, 2014** and continue until substantial

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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** section and click on **State** and select the following:

- BFS Letters (06/30/11)

[2001-10 Long Term Care Informal Dispute Resolution Process](#)
[2001-10 IDR Request Form](#)

This request must be received by **May 6, 2014**. If your request for informal dispute resolution is received after **May 6, 2014**, 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, comments or concerns, please contact Lorene Kayser, L.S.W., Q.M.R.P. or David Scott, R.N., Supervisors, Long Term Care at (208) 334-6626.

Sincerely,



DAVID SCOTT, R.N., Supervisor
Long Term Care

DS/dmj
Enclosures

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

PRINTED: 04/23/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135106 RECEIVED	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/11/2014
NAME OF PROVIDER OR SUPPLIER RIVER RIDGE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 640 FILER AVENUE WEST TWIN FALLS, ID 83301	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	FACILITY STANDARDS 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 annual federal recertification and complaint survey of your facility. The surveyors conducting the survey were: Rebecca Thomas, RN, Team Coordinator Brad Perry, BSW, LSW The survey team entered the facility on April 7, 2014, and exited on April 11, 2014. Survey Definitions: ADL = Activities of Daily Living BIMS = Brief Interview for Mental Status CNA = Certified Nurse Aide DON = Director of Nursing LN = Licensed Nurse MAR = Medication Administration Record MCO = Manager of Clinical Operations MDS = Minimum Data Set assessment mg = Milligrams PRN = As Needed	F 000	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, River Ridge 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 226 Affected Residents: On 11 April 2014, the reportable for Residents 5 & 10 was copied for the Surveyor. On 13 April 2014, the reportable and associated Accident and Incident report were reviewed by the administrator and found to be complete. The allegations were found to be unsubstantiated. Residents #5 and #10 were reviewed by licensed nursing personnel and remain free from adverse effect or signs and symptoms of abuse. Potential residents: On 6 May 2014, abuse investigations completed for the last 30 days were reviewed by the Administrator to ensure any abuse allegations were investigated and reported per policy and fax confirmation attached with no further findings noted	05/16/14
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record review, review of abuse policies and procedures, review of abuse investigation reports, and staff interview, it was determined the	F 226		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Jan D. Nye* TITLE: *Administrator* (X6) DATE: *05-06-14*

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 226	<p>Continued From page 1</p> <p>facility failed to operationalize its abuse policies and procedures when it did not ensure all allegations of abuse/neglect investigation results were reported to the state survey and certification agency in accordance with state law. This was true for 1 Unusual Occurrence Investigation reviewed for Resident #'s 5 and 10. Failure to submit the investigations report of potential abuse/neglect placed the residents at risk for abuse. Findings included:</p> <p>The facility's Abuse Prohibition policies and procedures dated 7/1/13, documented in part, "8. The Administrator or designee will report findings of all completed investigations to the Department within five (5) working days of the incident and take all necessary, corrective actions depending on the result of the investigation; 8.2 Fax the completed investigations to ...; and 10. All documentation related to allegations of abuse will be maintained at the Center for not less than three (3) years."</p> <p>The Bureau of Facility Standards Informational Letter 2005-1 documented in part, "Fax the completed investigation to the survey agency within five (5) working days..."</p> <p>On 7/2/13 the facility phoned in a report of possible neglect for Resident #'s 5 and 10 to the state survey and certification agency. The state survey agency did not receive a copy of the investigation report.</p> <p>On 4/8/14 the facility's Abuse investigations were reviewed, which included the investigation in question. The other investigations contained a fax confirmation attached to the report, which indicated they had been received by the state</p>	F 226	<p>Systemic:</p> <p>On 18 April 2014, the reportable form used by this facility will be re-drafted by the Administrator so that the fax telephone number is highlighted and separated from the reporting number.</p> <p>On or before 18 April 2014, fax confirmation sheets will be stapled to reports.</p> <p>Beginning 18 April 2014, each reportable will be reviewed in Daily Stand-up meeting to ensure the report is complete and verification of transmission is present.</p> <p>On 10 April 2014, education was provided to the facility Administrator by Regional Vice president regarding time frame of reports sent to dept. of health and welfare, and handling the fax confirmations to ensure transmission.</p> <p>QA Follow-up – Audits:</p> <p>Beginning 10 May 2014, state reportable investigations will be reviewed by the Administrator and Business Office Manager in the Business excellence PI Committee monthly for 4 months to ensure that state reportable investigations include fax confirmation of receipt to the State Bureau of Facility Standards. The results of these audits will be reported to the Performance Improvement committee by the Administrator for review for 3 months or until resolved. Compliance will be monitored by the Administrator</p>	

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F 226	<p>Continued From page 2</p> <p>survey agency, however, the report in question did not contain such a confirmation page.</p> <p>On 4/8/14 at 2:45 PM, the Administrator was interviewed regarding the report. He said he called the initial alleged incident into the state survey hotline and stated, "I'm almost sure I faxed it in." When asked to produce the documentation or a fax confirmation page he said he would look for it.</p> <p>On 4/8/14 at 3:30 PM, the Administrator told the surveyor he could not find the fax confirmation.</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations and staff interviews, it was determined the facility failed to maintain residents' dignity by exposing their buttocks in the hallway of the facility and when a resident's catheter leg bag was exposed while sitting across from the nurses station. This was true for 1 of 1 (#11) random residents seen in a shower chair in the facility hallway and for 1 of 9 (#7) sampled residents. This created the potential for a negative effect on residents' self-esteem. Findings included:</p> <p>1. On 4/9/14 at 10:16 AM, CNA #1 was observed wheeling Resident #11 in a reclining shower chair</p>	F 226	<p>F 241</p> <p>Affected Residents: On 08 April 2014, the Unit Manager updated the care plan and care kardex for resident #7 for placement of his catheter bag to insure resident dignity and concealment of the bag. On 08 April 2014, resident #7 was assessed by the Director of Nursing for psychosocial harm with none found. On 09 April 2014 resident #11 was assessed for psychosocial harm by the Social Service Director. No adverse reactions were noted. The CNA's were educated on resident dignity and ensuring that residents are not exposed when transporting them to and from the shower room by the Director of Nursing on 9 April 2014.</p> <p>Potential residents: The Director of Nursing completed a center round on 9 April 2014, to ensure residents were properly covered during transfers to showers and drainage bags were properly concealed with no further dignity issues noted.</p> <p>Systemic: On or before 16 May 2013, nursing staff will receive re-education by the Nurse Practice Educator on resident dignity, catheter bag placement, and proper use of ponchos during transport and undressing residents in the shower room prior to bathing.</p>	05/16/14
F 241 SS=D		F 241		

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F 241	<p>Continued From page 3</p> <p>down the hall and into the 200 hallway shower room. The resident was reclined in the chair and a white blanket covered him. However, the blanket was not covering either leg from his bare feet to just above his knee caps. At 10:28 AM, CNA #2 was observed wheeling the resident out of the shower room and down the hall. The resident's left upper thigh, buttocks, and lower back were exposed through a six to eight inch gap between the shower chair and the blanket. The resident was wheeled past another resident and a therapy assistant, who had visual access to the resident's exposed skin.</p> <p>On 4/9/14 at 10:40 AM, CNA #2 was interviewed regarding the observation. When asked if the resident was naked underneath the blanket, she said he was and stated, "I thought I had it tucked." When asked about the shower process, she said residents were normally transferred to the shower room wearing a hospital type gown, however, Resident #11 had an infected wound on his left side and didn't want to bother with a gown in case it came into contact with the infected wound.</p> <p>On 4/9/14 at 11:55 AM, the DON was interviewed regarding the wound; she stated the wound was covered by a dressing and there should be no reason why the resident should be transported without the gown.</p> <p>2. On 4/8/14 from 11:08-11:23 AM, Resident #7 was observed sitting in a chair, across from the nurses station, with half of his right leg catheter bag protruding from his pant leg, near his ankle. The bag was not covered with a privacy cover and urine was observed inside the bag. During the observation there were three staff members</p>	F 241	<p>QA Follow-up – Audits:</p> <p>On or before 16 May 2014, one shower audits and one dignity round will be conducted by the Director of Nursing or designee, weekly for 4 weeks and monthly for 3 months, to insure proper placement and concealment of catheter bags, and dignity during shower transport. The results of these audits will be reported to the Performance Improvement Committee for review for 4 months or until resolved.</p> <p>Compliance will be monitored by the Director of Nursing.</p>		

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F 241	Continued From page 4 at the nurses station and two other staff members walked past the resident without concealing the catheter bag. On 4/8/14 at 11:23 AM, LN #3 was informed of the observation and she stated, "He needs his catheter changed. I will follow up with that, right now." LN #3 then left to assist the resident. On 4/9/14 at 6:30 PM, the Administrator and DON were informed of the dignity issues. No further information was provided.	F 241			
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced	F 280	F 280 Affected Residents: On 09 April 2014, the care plan for resident 2 was audited and updated by the Unit Manager to include information on the floor mat. On 09 April 2014, the care plan for resident 6 was audited and updated by the Unit Manager to include information on the prosthesis. Potential residents: On or before 16 May 2014, care plans will be audited by the Director of Nursing or designee to ensure they are updated for prosthetics and floor mats as needed. Systemic: On or before 16 May 2014, nursing personnel will be reeducated by the Nurse Practice Educator with respect to the updating and accuracy of care plans. QA Follow-up – Audits: On or before 16 May 2014, 3 care plans will be reviewed by the Director of Nursing or designee, weekly for 4 weeks and monthly for 3 months, to ensure that they reflect current care needs. The results of these audits will be reported to the Performance Improvement Committee monthly for 4 months or until resolved. Compliance will be monitored by the Director of Nursing.	05/16/14	

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F 280	<p>Continued From page 5</p> <p>by:</p> <p>Based on observation, record review, and staff interview, it was determined the facility failed to revise care plans for 2 of 9 sampled residents (#'s 2 & 6). The care plan did not include information for staff regarding a resident's leg prosthesis and did not include an intervention of a fall mat which was used. This had the potential to result in harm if residents did not receive appropriate care due to lack of direction in the care plan. Findings include:</p> <p>1. Resident #6 was admitted to the facility on 2/7/14 with multiple diagnoses including traumatic below the knee amputation.</p> <p>The resident's Admission Nursing Assessment, dated 2/7/14, and 14 day MDS Assessment, dated 2/14/14, documented the resident did not have a prosthetic limb.</p> <p>On 4/7/14 at 2:00 PM, the resident was observed in her room with a below the knee prosthesis attached to her left leg.</p> <p>Upon review of the resident's care plan, it was determined there was no mention of the prosthetic, what staff should know about it, or how staff should take care of it.</p> <p>On 4/9/14 at 3:45 PM, the DON and MCO were interviewed regarding the issue. When asked why the MDS Assessment did not document the prosthetic limb, the DON said the resident did not bring the prosthetic limb with her until sometime after the assessment and said she would look for the care plan.</p> <p>On 4/10/14 at 8:45 AM, the DON stated the</p>	F 280		

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F 280	Continued From page 6 prosthetic limb, "Was not on the care plan." 2. Resident #2 was readmitted to the facility on 9/25/07 with multiple diagnoses including Alzheimer's disease and muscular wasting and disuse atrophy. On 4/7/14 at 1:43 PM and on 4/8/14 at 7:40 AM, 9:15 AM, 10:17 AM, and 11:07 AM, a fall mat was observed on the floor between the resident's bed and wall. Upon review of the resident's "Risk for falls..." care plan revision, dated 5/22/13, it was determined a fall mat was not included as an intervention. On 4/9/14 at 10:50 AM, the DON was interviewed regarding the care plan. The DON said she would check the care plan. On 4/10/14 at 9:57 AM, Unit Manager #4 brought the surveyor a care plan with an intervention for a fall mat dated 11/19/13, however she said it was a previous care plan and stated the intervention for a fall mat, "...didn't make it to the new care plan." On 4/10/14 at 2:55 PM, the Administrator, DON, and MCO were informed of the care plan issue. No further information was provided by the facility.	F 280			
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	F 309	F 309 Affected Residents: On 9 April 2014, resident # 9 was assessed by the Director of Nursing for signs and symptoms of infection, bruit and thrill, respiratory status, and edema checks for fluid overload with no adverse reaction. Potential residents: On 9 April 2014, a review of residents who require hemodialysis was completed by the Director of Nursing to ensure that resident care and assessments were completed and documented. Follow up was completed as needed.	05/16/14	

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F 309	<p>Continued From page 7</p> <p>accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility failed to ensure residents received the necessary care and services to attain or maintain their highest practicable well-being by not following physician orders to restrict fluids, monitor an arteriovenous fistula/graft site, auscultate a bruit, and palpate a thrill. This was true for 1 of 9 (#9) sampled residents created the potential for harm for those residents on Dialysis should they experience fluid overload, develop an aneurysm at the fistula site or have an infected graft. Findings included:</p> <p>Resident #9 was admitted to the facility on 9/1/11, and readmitted 1/8/14, with multiple diagnosis which included ESRD (End Stage Renal Disease).</p> <p>Record review revealed the resident received dialysis treatment weekly on Monday, Wednesday and Friday.</p> <p>Recapitulated physician orders for March and April of 2014, documented: **Auscultate bruit and palpate thrill every shift - night shift, day shift, everyday; *Monitor AV fistula/graft site for signs/symptoms of infection, edema, bleeding - night shift day shift, everyday; *Notify physician for absence of bruit/thrill - PRN; and, *Fluid Restriction: 1500 ml/24 hr [hour] Nursing to</p>	F 309	<p>Systemic: On or before 16 May 2014, licensed nurses will be educated as to the importance of accurate assessment and associated MAR / TAR documentation.</p> <p>QA Follow-up – Audits: On or before 16 May 2014, the Director of Nursing or designee will audit MAR's and TAR's for 3 residents requiring dialysis, for completion of documentation. These audits will continue and be completed weekly for 4 weeks and monthly for 3 months. The results of these audits will be reviewed by the Performance Improvement Committee for 4 months or until resolved. Compliance will be monitored by the Director of Nursing</p>	

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F 309	<p>Continued From page 8</p> <p>provide/monitor fluid intake at meals and in-between - night shift, day shift, everyday for ESRD."</p> <p>The resident 's TAR (Treatment Administration Record) did not document that staff auscultated the bruit and palpated the thrill for the following shifts: *Day shift on 3/14, 3/18, 3/25, 3/31 and 4/9; and, *Night shift on 3/27, 3/31, 4/5 and 4/8.</p> <p>The TAR did not document staff monitored the AV fistula/graft site for signs/symptoms of infection, edema, and bleeding for the following shifts: *Day shift on 3/14, 3/18, 3/25, 3/31, and 4/9; and, *Night shift on 3/27, 3/31, 4/5 and 4/8.</p> <p>The TAR did not document nursing provided or monitored fluid intake at meals and in-between for the following shifts: *Day shift on 3/3, 3/4, 3/7 - 3/13, 3/20, 3/24 - 4/1 and 4/6 - 4/9. *Night shift on 3/1, 3/3, 3/9, 3/10, 3/15 - 3/16, 3/20, 3/23 - 3/25, 3/27 - 4/1, and 4/7 - 4/8.</p> <p>Additionally, there was a column for daily totals of fluid intake on the TAR which was not filled in for the months of March and April 2014, indicating fluids were not being monitored as ordered.</p> <p>On 4/10/14 at 12:20 PM, the DON and MCO were interviewed and shown the TAR for the months of March and April 2014. The DON stated staff should have documented auscultation of the bruit, the AV fistula/graft site and the fluid restriction.</p> <p>On 4/10/14 at 2:55 PM, the Administrator, DON and MCO were made aware of the above</p>	F 309			

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F 309	Continued From page 9 concerns. No further documentation was provided.	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. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure a siderail was assessed as safe for resident use. This affected 1 of 9 (#6) sampled residents and placed the resident at risk for entrapment and potential harm should the resident become entrapped in the siderail. Findings included: Resident #6 was admitted to the facility on 2/7/14 with multiple diagnoses including traumatic below the knee amputation and muscular wasting and disuse atrophy. On 4/7/14 at 2:00 PM and throughout the survey, the resident's bed was observed with a 1/4 siderail to the right side of her bed and in the upright position. Upon review of the resident ' s medical record, no documented assessment was found to show the resident was safe with the siderail.	F 323	F 323 Affected Residents: On 9 April 2014, the quarter side rail safety evaluation for resident 6 was completed by the Unit Manager, and was found to be safe for this resident. On 9 April 2014, resident #6 was assessed by the Director of Nursing for any injury or negative effect from side rail use with none noted. Potential residents: On or before 16 May 2014, residents will be reviewed by the Unit Manager for quarter side rail utilization, and presence of safety assessments. Corrections will be completed as necessary. Systemic: On or before 16 May 2014, licensed nursing staff will be re-educated regarding safety assessments for residents who utilize quarter side rails. QA Follow-up – Audits: On or before 16 May 2014, audits of 3 residents that require side rail utilization will be completed weekly for 4 weeks, then monthly for 3 months by the Director of Nursing or designee for the presence of a safety assessment. The results of these audits will be reported to the Performance Improvement Committee Monthly for 4 months or until resolved. Compliance will be monitored by the Director of Nursing	05/16/14	

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F 323	Continued From page 10 On 4/8/14 at 3:45 PM, the DON and MCO were informed of the issue and the DON said she would look for the assessment. On 4/10/14 at 8:45 AM, the MCO stated, "We couldn't find a previous completed assessment." On 4/10/14 at 2:55 PM, the Administrator, DON, and MCO were informed of the issue. No further information was provided.	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. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident and staff interview, it was determined the facility failed to ensure residents who used oxygen received the liter flow as ordered by the physician, nor did the physician recapitulation orders include an order for oxygen although a resident had received oxygen. This was true for 1 of 3 sampled residents (#6) and created the potential for harm should residents receive	F 328	F 328 Affected Residents: On 10 April 2014, Resident # 6's respiratory status was assessed by the Unit Manager with no negative findings. The physician and family were notified. On April 10 2014, the hospital order for oxygen was clarified and discontinued by the physician, and the oxygen was removed from her room by the licensed nurse. Potential residents: On or before 16 May 2014, a review of other residents utilizing oxygen will be completed by the Director of Nursing or designee to ensure orders include the flow rate and delivery method. Corrections will be implemented as necessary.	05/16/14

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F 328	<p>Continued From page 11</p> <p>oxygen therapy at different concentrations than ordered by the physician. Findings included:</p> <p>Resident #6 was admitted to the facility on 2/7/14 with multiple diagnoses including traumatic below the knee amputation and muscular wasting and disuse atrophy.</p> <p>The resident had two Admission Orders/Medication Reconciliation dated 2/7/14 in her medical record. They were identical except one was stamped, "Faxed Copy" and under Additional Orders a handwritten telephone order documented, "Oxygen [at] 4 L[iters] continuous."</p> <p>The resident's Admission Nursing Assessment, dated 2/7/14, documented the resident received oxygen at 4 liters per minute.</p> <p>The resident's April 2014 Recapitulation orders, dated 2/7/14, documented: "Change humidifier bottle on oxygen concentrator weekly and as needed...; Change humidifier tubing weekly...; Change oxygen tubing weekly...; and, Clean oxygen concentrator filter weekly." Note: Liter flow and how the resident received the oxygen was not found on the Recapitulation orders or the April 2014 MAR.</p> <p>The resident's Interdisciplinary Progress Notes documented the following observations of the resident: "2/7/14- 7:00 PM, ...O2 [oxygen] on 4 LPM [liter per minute]; 2/8/14- 5:30 AM, O2 on per nasal canula[NC]; 2/9/14- 3:30 AM, ...2 L O2; 2/16/14- 3:00 AM, O2 on per NC...on 2 L; 2/20/14- 2:35 AM, O2/NC."</p>	F 328	<p>Systemic: On or before 16 May 2014, admitted residents will be reviewed in the clinical stand up meeting to insure accuracy of orders. On or before May 16 2014 nursing staff will be educated by the Nurse Practice Educator on obtaining complete physician orders for oxygen administration.</p> <p>QA Follow-up – Audits: On or before 16 May 2014 the Director of Nursing or designee will audit, 3 residents who require oxygen administration to ensure that physician orders for oxygen administration include a flow rate and delivery method. Audits will be implemented and completed weekly for 4 weeks, then monthly for 3 months, The results of these audits will be reported to the Performance Improvement Committee for review Monthly for 4 months or until resolved. Compliance will be monitored by the Director of Nursing</p>	

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F 328	<p>Continued From page 12</p> <p>The resident's care plan, dated 4/7/14, documented: * Focus - "Altered Respiratory Status: shortness of breath/difficulty breathing related to: Oxygen dependence;" and, * Interventions - "Provide oxygen as ordered."</p> <p>The following observations and resident interview were conducted: -4/7/14 at 2:00 PM, the resident was observed in her room without oxygen on her person. An oxygen concentrator was sitting against the wall, turned on and was set for 2 liters; -4/8/14 at 9:21 AM, the resident was observed in her bed eating breakfast without oxygen on her person, but the concentrator was turned on; -4/9/14 at 10:12 AM, the resident was not in her room and the oxygen concentrator was not turned on; -4/9/14 at 11:58 AM, the resident was interviewed regarding her use of oxygen. She said she "sometimes" used the oxygen; and -4/10/14 at 8:15 AM, the oxygen concentrator was absent from the resident's room.</p> <p>On 4/10/14 at 8:45 AM, the DON and MCO were interviewed regarding the oxygen issue. The DON stated, "I don't believe she had an actual order...I don't think she's getting it. I have never seen her with an oxygen canula on." The surveyor informed her of the nurses notes which documented the oxygen on the resident, the observations of the concentrator in the room, the interview with the resident, and showed her the conflicting Admission Orders. The DON said prior to the resident coming to the facility, the resident's Admission Orders, which contained the handwritten order, was faxed to the facility. At this</p>	F 328			

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F 328	Continued From page 13 time the change and cleaning orders of the oxygen equipment were placed on the resident's recapitulated orders and the MAR. However, when the resident came into the facility she brought Admission Orders which did not include the handwritten order. She said the facility contacted the physician for a clarification and the physician discontinued the oxygen, but the changing and cleaning portion was left on the recapitulation order and MAR. The surveyor requested a copy of the clarification order for the oxygen. At 2:10 PM, the DON informed the surveyor she could not find the clarification order. On 4/10/14 at 2:55 PM, the Administrator, DON, and MCO were informed of the oxygen issue. No further information or documentation was provided.	F 328			
F 369 SS=D	483.35(g) ASSISTIVE DEVICES - EATING EQUIPMENT/UTENSILS The facility must provide special eating equipment and utensils for residents who need them. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility did not provide special eating equipment for a resident who needed it. This was true for 1 of 6 residents (#4) sampled for assistive devices. This deficient practice placed the resident at risk of harm for compromised nutritional status. Findings included: Resident #4 was originally admitted to the facility on 7/6/10, and readmitted on 9/27/10, with	F 369	F 369 Affected Residents: On 8 April 2014, resident number 4 was provided with the proper lip plate. At the time the lip plate was provided, the resident was observed by the licensed nurse, who noted no adverse effects. On or before 16 May 2014, resident #4 will be assessed by the occupational therapist to ensure that ongoing use of the lip plate was needed. No changes to the plan of care were needed. Potential residents: On or before 16 May 2014, residents with care planned meal specific adaptive equipment will be observed during meals by the Dining Room Managers to ensure the equipment is present and utilized. Corrections will be made as necessary. Systemic: On or before 16 May 2014, center staff will be educated by the Nurse Practice Educator to check the resident's tray card when meals are served to ensure that adaptive equipment is provided as ordered.	05/13/14	

PER TELEPHONE
CONVERSATION WITH THE
ADON ON 5/16/14 AT
1:30PM, CHANGED
COMPLETION DATE
ON THIS PAGE.
BRAD BERRY

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F 369	Continued From page 14 multiple diagnosis which included muscle weakness, lack of coordination, muscular wasting and disuse atrophy. On 4/8/14 at 8:20 AM, the resident was observed in the dining room eating breakfast. The tray card on the table documented the resident needed a "Lip Plate, [and] NoseyCup." The surveyor asked CNA #4 and LN #3 if the resident had a lipped plate. LN #3 stated, "No, she does not." CNA #4 left the dining room and returned with a lipped plate of food for the resident. On 4/10/14 at 2:55 PM, the Administrator and DON were made aware of the assistive eating device issue. No further information was provided by the facility.	F 369	QA Follow-up – Audits: On or before 16 May 2014, an audit of 3 residents with assistive devices will be audited by the Dining Room Managers weekly for 4 weeks, then monthly for 3 months to ensure the presence of adaptive equipment. The results of these audits will be reported to the Performance Improvement Committee monthly for 4 months for review. Compliance will be monitored by the Director of Nursing F 431 Affected Residents: On 08 April 2014, the pharmacy was contacted by the Director of Nursing regarding the medication for resident #8. After consultation with the pharmacy, a correctly labeled medication card was obtained. Although the medication dose was incorrect on the label, resident #8 actually received the correct dose as ordered. Resident #8 was assessed by the Director of Nursing on 08 April 2014 and found not to be negatively affected. On 09 April 2014, expired medications which were found on the medication cart and in the medication room were destroyed. Potential residents: On 09 April 2014, medications were reviewed by the Director of Nursing and the Unit Manager to ensure that medication cards matched the medication administration record and MD orders. Any findings were corrected.	05/16/14	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in	F 431			

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F 431	<p>Continued From page 15</p> <p>locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure a medication label contained the correct dosage ordered by the physician and expired medications were not available for administration to residents. This was true for 1 out of 6 sampled residents (#8) during the medication pass observation, and created the potential for the resident to receive a higher dose of medication than what the physician ordered. Additionally, over-the-counter (OTC) medications were found in the Supply Room, as well as the Pine Hall and Medicare Medication Carts, which were expired. This had the potential to affect most residents in the facility who received medications from the Supply Room and the Pine Hall and Medicare Medication Carts and created the potential for sub-optimal efficacy for any resident who could have received the expired medication. Findings included:</p> <p>On 4/8/14 at 8:00 AM, during the medication pass</p>	F 431	<p>Systemic: On or before 16 May 2014, licensed staff will receive in-service by the Nurse Practice Educator regarding check-in of pharmacy deliveries, stocking of medication carts, and expiration dates. On or before 16 May 2014, The Central Supply Designee will be educated regarding stocking of medication, and expiration dates.</p> <p>QA Follow-up – Audits: On or before 16 May 2014, audits of 1 medication cart and 1 medication storage area will be implemented and completed weekly for 4 weeks, and then monthly for 3 months by the Director of Nursing or designee to ensure accurate medication labeling and that expired medications do not remain on hand in carts or supply room. Issues regarding medications will be corrected as necessary. The results of these audits will be reviewed by the Performance Improvement Committee monthly for 4 months or until resolved. Compliance will be monitored by the Director of Nursing</p>	

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F 431	<p>Continued From page 16 observation with LN #3, Seroquel (Quetiapine Fumarate) 100 mg was given to Resident #8. The medication label documented, "Take 1 tab by mouth twice daily (take with 25 mg to equal 125 mg)." LN #3 was interviewed regarding the 125 mg dosage, which had been listed on the label. She stated the resident was now taking 100 mg of Seroquel, the label was incorrect and the medication card needed a new label. She then pulled the medication card and took it to the nurses station. She stated she would make sure it had the correct label.</p> <p>Resident #8's Active Orders (Recapitulation) for April 2014 documented an order for Seroquel (Quetiapine Fumarate) 100 mg tablet by mouth every 12 hours daily with a start date of 9/27/2013.</p> <p>On 4/9/14 at 5:15 PM, during an inspection of the Medicare Medication Cart with LN #6 in attendance, the following OTC medications were found to be expired: *Famotidine 10 mg tablets, six (6) tablets - expired on June 2013; *Milk of Magnesia, 16 oz bottle which was 3/4 full - expired November 2013; *Natural Fiber Powder, 10 oz bottle which was almost full - expired on 3/20/14; and, *Ferrous Gluconate Tablets 324 mg, 80 tablets - expired on 3/20/14.</p> <p>On 4/9/14 at 5:30 PM, LN #6 stated she would give the above expired medications to LN #4, Unit Manager, for destruction per the facility policy.</p> <p>On 4/9/14 at 5:45 PM, during an inspection of the</p>	F 431		
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F 431	Continued From page 17 Pine Hall Medication Cart with LN #3 in attendance, the following OTC medications were found to be expired: *A bottle of Oyster Shell Calcium 500 mg with Vitamin D Dietary Supplement tablets was found to be 2/3 full with no expiration date on the bottle; and, *Milk of Magnesia, 16 oz bottle which was almost full - expired November 2013. On 4/9/14 at 5:55 PM, LN #3 gave the expired medications to LN #4, Unit Manager, for destruction per the facility policy. LN #4 was interviewed and stated the expiration date should have been checked when stocked in Central Supply and before opening the bottle. She stated the expiration date could have been wiped off the bottom of the bottle with an alcohol wipe. On 4/9/14 at 6:05 PM, during an inspection of the Central Supply Room with LN #4, three (3) 10 oz bottles of Magnesium Citrate with an expiration date of March 2014 were found on the shelf available for resident use. LN #4 stated the bottles should not be on the shelf and she would destroy the bottles per the facility policy. On 4/10/14 at 12:00 PM, the DON and MCO were informed of the labeling issue and the expired medications. No further information was provided by the facility.	F 431		
F 468 SS=E	483.70(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS The facility must equip corridors with firmly secured handrails on each side.	F 468	F 468 Affected Residents: On 25 April 2014, residents 2,4,5,6,7, and 8 were assessed, and noted to have no adverse effects. On or before 16 May 2014, handrails will be installed in the cited sections of hallway. Potential residents: On 24 April 2014, handrails in the facility were inspected by the Maintenance Director, with all areas of hallway – other than the two cited areas - found to be compliance. Systemic: Education was provided to the facility Maintenance Director by the facility Administrator on 24 April 2014, to ensure that handrails are present and stable along indoor facility walkways. On or before 16 May 2014, the center staff will be educated by the Maintenance Director to notify the Maintenance Director if handrails are noted to be missing or in need of repair.	05/16/14

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

PRINTED: 04/23/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135106	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2014
NAME OF PROVIDER OR SUPPLIER RIVER RIDGE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 640 FILER AVENUE WEST TWIN FALLS, ID 83301		
(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 468	<p>Continued From page 18</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure all corridors were equipped with handrails. This affected 6 of 9 (#s 2 and 4-8) sampled residents and had the potential to affect other residents who frequented the corridors without handrails. This practice created the potential for residents to not have a handrail for stability when needed. Findings included:</p> <p>On 4/7/14 at 1:50 PM, approximately 4 feet of handrails were observed to be missing on both sides of the hallway next to and across from resident room #126.</p> <p>On 4/10/14 at 8:07 AM, Resident #7 was observed holding onto handrails with his left hand and holding a facility staff member's right hand while walking down the hallway. When the resident reached the area with missing handrails, the resident was observed to lean more on the staff member for support.</p> <p>On 4/9/14 at 4:05 PM, during the environmental tour, the Maintenance Supervisor was shown the missing handrails and he stated there used to be divider doors where there was an absence of handrails, but the doors were taken down approximately 14 years ago and handrails were never put up. The Maintenance Supervisor stated, "We can fix that."</p> <p>On 4/9/14 at 6:30 PM the Administrator and DON were informed of the issue. No further information was provided by the facility.</p>	F 468	<p>QA Follow-up – Audits: On or before 16 May 2014, the Maintenance Director will complete a facility round to ensure that handrails are present and in good repair weekly for 4 weeks and then monthly for 3 months. The results of these audits will be reported to the Performance Improvement Committee for review X 4 months or until resolved. Compliance will be monitored by the Administrator.</p>	

DÉPARTMENT OF HEALTH AND HUMAN SERVICES
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Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001650	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/11/2014
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NAME OF PROVIDER OR SUPPLIER RIVER RIDGE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 640 FILER AVENUE WEST TWIN FALLS, ID 83301
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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) COMPLETE DATE
C 000	16.03.02 INITIAL COMMENTS The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2. The following deficiencies were cited during the State licensure and complaint survey of your facility. The surveyors conducting the survey were: Rebecca Thomas, RN, Team Coordinator Brad Perry, BSW, LSW	C 000	C 125 Please refer to Plan of Correction for the cited deficiency F 241.	05/16/14
C 125	02.100,03,c,ix Treated with Respect/Dignity 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 regarding a resident's exposed catheter bag and a resident's exposed buttocks.	C 125	C 389 Please refer to Plan of Correction for the cited deficiency F 468.	05/16/14
C 389	02.120,03,d Sturdy Handrails on Both Sides of Halls d. Handrails of sturdy construction shall be provided on both sides of all corridors used by patients/residents. This Rule is not met as evidenced by: Refer to F468 regarding lack of handrails.	C 389	C 782 Please refer to Plan of Correction for the cited deficiency F 280.	05/16/14
C 782	02.200,03,a,iv Reviewed and Revised iv. Reviewed and revised as needed to reflect the current needs of	C 782		

RECEIVED
MAY - 7 2014
FACILITY STANDARDS

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
<i>Jan D. Agan</i>	Administrator	05-06-14

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001650	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 04/11/2014
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NAME OF PROVIDER OR SUPPLIER RIVER RIDGE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 640 FILER AVENUE WEST TWIN FALLS, ID 83301
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C 782	Continued From page 1 patients/residents and current goals to be accomplished; This Rule is not met as evidenced by: Refer to F280 regarding care plans not being updated for use of a fall mat and a prosthetic limb.	C 782		
C 784	02.200,03,b Resident Needs Identified 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: Pleae refer to F-309 as it relates to highest practical care.	C 784	C 784 Please refer to Plan of Correction for the cited deficiency F 309.	05/16/14
C 787	02.200,03,b,iii Fluid/Nutritional Intake iii. Adequate fluid and nutritional intake, including provisions for self-help eating devices as needed; This Rule is not met as evidenced by: Please refer to F-369 as it relates to dietary services.	C 787	C 787 Please refer to Plan of Correction for the cited deficiency F 369.	05/16/14
C 790	02.200,03,b,vi Protection from Injury/Accidents vi. Protection from accident or injury; This Rule is not met as evidenced by: Refer to F323 regarding side rail safety assessments.	C 790	C 790 Please refer to Plan of Correction for the cited deficiency F 323.	05/16/14

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001650	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/11/2014
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C 798	Continued From page 2	C 798		
C 798	02.200,04,a MEDICATION ADMINISTRATION Written Orders 04. Medication Administration. Medications shall be provided to patients/residents by licensed nursing staff in accordance with established written procedures which shall include at least the following: a. Administered in accordance with physician's dentist's or nurse practitioner's written orders; This Rule is not met as evidenced by: Please refer to F328 as it relates to oxygen administration in accordance with physician order.	C 798	C 798 Please refer to Plan of Correction for the cited deficiency F 328.	05/16/14
C 821	02.201,01,b Removal of Expired Meds b. Reviewing all medications in the facility for expiration dates and shall be responsible for the removal of discontinued or expired drugs from use as indicated at least every ninety (90) days. This Rule is not met as evidenced by: Please refer to F-431 as it relates to expired medications.	C 821	C 821 Please refer to Plan of Correction for the cited deficiency F 431	05/16/14



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

May 13, 2014

FILE COPY

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

Provider #: 135106

RE: Corrected copy of the April 11, 2014, Complaint Investigation findings for
Complaint #6092

Dear Mr. Hayes:

On April 11, 2014, a Complaint Investigation was conducted in conjunction with the Recertification & State Licensure survey of April 11, 2014. On **May 9, 2014**, your facility was sent a letter from our office notifying you of the results of that survey.

The May 9, 2014, findings letter is revised as follows as the previous sent findings letter erroneously identified the complaint as an entity-reported incident and the last paragraph needed to be deleted:

On **April 11, 2014**, a Complaint Investigation survey was conducted at River Ridge Center. Becky Thomas, R.N. and Bradley Perry, L.S.W. conducted the complaint investigation. The complaint was investigated in conjunction with the facility's annual Recertification and State Licensure survey conducted on April 7 through 11, 2014.

The following observations were completed:

- Two shower rooms used by the residents were observed;

James H. Hayes, Administrator
May 13, 2014
Page 2 of 7

- Two housekeepers were observed cleaning shower rooms;
- Seven residents' and several others in the facility were observed for care needs; and
- Medication Administration Records were observed on nursing carts.

The following documents were reviewed:

- The facility's Incident and Accident reports from May 2013 through April 2014;
- The facility's Resident-to-Resident and Allegation of Abuse reports from May 2013 through April 2014;
- The facility's grievance logs from May 2013 through April 2014;
- Resident Council minutes from January 2014 through April 2014;
- Nurse Staffing records for June 26, 2013;
- The entire medical record of two identified residents; and
- Seven residents' records were reviewed for Quality of Life and Quality of Care concerns.

The following interviews were completed:

- Five residents were interviewed at a group interview regarding incontinent care, residents falling asleep in chairs and shower cleanliness;
- Three residents were interviewed individually regarding incontinent care and shower cleanliness;
- Two residents' family members were interviewed regarding incontinent care, residents falling asleep in chairs and shower cleanliness;
- Two CNAs were interviewed regarding incontinent care and residents falling asleep in chairs;
- Two housekeepers were interviewed regarding cleaning practices of the shower rooms;
- Three nurses were interviewed regarding protecting residents' privacy when using the Medication Administration Record;
- The District Manager of Housekeeping was interviewed regarding cleaning practices of the shower rooms;
- The Director of Nursing was interviewed regarding incontinent care, residents falling asleep in chairs and Medication Administration Record privacy issues; and
- The Administrator was interviewed regarding an investigation based on a corporate complaint of potential neglect for two identified residents.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00006092

ALLEGATION #1:

The complainant stated on the afternoon of June 26, 2013, an identified resident was observed sleeping in her wheelchair with her head tilted forward and was about to fall out of her wheelchair. A staff member asked another staff member to help the resident, but the second staff member would not help.

FINDINGS:

The identified resident was no longer residing in the facility at the time the complaint was investigated.

During the initial tour and throughout the remainder of the survey, residents were observed for sleeping in their wheelchairs. There were no residents found sleeping in their chairs with their heads tilted forward and about to fall out.

The facility's grievance files and resident council minutes did not reveal that residents falling asleep in a chair was an issue.

The identified resident's medical record did not document the resident fell asleep in her wheelchair and was about to fall out.

An Allegation of Abuse investigation and Incident and Accident report was reviewed, and the report documented the identified resident had been drowsy during an activity and staff responded appropriately by taking the resident to the nurses' station and then to bed.

The five residents interviewed at the group interview said staff are prompt to remove a resident who is falling asleep in their chair or to ask the resident if they needed to lie down.

The two residents' family members interviewed said staff are prompt to remove residents falling asleep in their chairs or to ask the residents if they need to lie down.

Two CNAs interviewed regarding residents found sleeping in their chairs said they would ask if they wanted to go and lie down or have them assessed by a nurse if other medical conditions were possibly present.

The Director of Nursing was interviewed and said staff is instructed to check with the resident to see if they want to lie down.

The Administrator was interviewed regarding the facility's investigation of the alleged incident,

James H. Hayes, Administrator
May 13, 2014
Page 4 of 7

and he said witnesses were interviewed per policy; however, the person reporting the incident to the facility would not speak to him about the alleged incident.

Based on observations, records reviewed and residents, family and staff interviews, the allegation could not be verified.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The complainant stated that on the afternoon of June 26, 2013, two identified resident's incontinent briefs were dripping urine and sagging due to being soaking wet. A staff member asked two other staff members to help the residents, but the staff members would not help.

FINDINGS:

One of the two identified residents was no longer residing in the facility at the time the complaint was investigated.

During the initial tour and throughout the remainder of the survey, residents were observed for dripping urine and sagging pants due to overly wet incontinence briefs. There were no residents found in either of these conditions and the smell of urine was not detected.

The facility's grievance files and resident council minutes did not reveal residents with improper incontinence care issues.

The two identified and seven other residents' medical records did not indicate an issue with incontinence care.

An Allegation of Abuse investigation and Incident and Accident reports were reviewed, and the reports documented the identified resident did not have urine dripping from her chair as described and the other identified resident did not have sagging pants and had been changed appropriately.

Nurse staffing records for June 26, 2013, were reviewed and one of the two staff members identified in the complaint was not identified as an employee.

The five residents interviewed at the group interview said staff are prompt to change incontinence briefs and provide appropriate care.

James H. Hayes, Administrator
May 13, 2014
Page 5 of 7

The two residents' family members interviewed said staff are prompt to change incontinence briefs and provide appropriate care.

Two CNAs interviewed regarding residents needing incontinence care said residents are changed on a regular basis. Both said if they ever found a resident in either condition described by the complainant, they would immediately change the resident and report the incident to the nurse in charge.

The Director of Nursing was interviewed and she said the staff are instructed to watch for any indications of wet incontinent briefs and for staff to change the resident immediately.

The Administrator was interviewed regarding the facility's investigation of the alleged incidents, and he said witnesses were interviewed per policy; however, the person reporting the incident to the facility would not speak to him about the alleged incident.

Based on observations, records reviewed and residents, family and staff interviews, the allegation could not be verified.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The complainant stated that on the afternoon of June 26, 2013, the shower room was dirty and had incontinent brief "stuffing" all over the floor.

FINDINGS:

During the initial tour and throughout the remainder of the survey, two shower rooms used by the residents were observed to be clean.

Two housekeepers were observed on different days cleaning the shower rooms.

The facility's grievance files and resident council minutes did not reveal shower rooms or facility's cleanliness was an issue.

Five residents were interviewed at a group interview regarding shower cleanliness and there were no concerns.

Three residents were interviewed individually regarding shower cleanliness and there were no

concerns.

Two residents' family members were interviewed regarding shower cleanliness and there were no concerns.

Two housekeepers were interviewed regarding cleaning practices of the shower rooms, and both said they cleaned it daily and when it needed it.

The District Manager of Housekeeping was interviewed regarding cleaning schedules and he said the shower rooms are checked at least three times a day between the housekeepers and housekeeper supervisors.

Based on observations, records reviewed and residents, family and staff interviews, the allegation could not be verified.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

The complainant stated a Medication Administration Record book was left open at the nurses' station, which allowed any resident or visitor walking by to view residents' confidential medication information.

FINDINGS:

During the initial tour and throughout the remainder of the survey, Medication Administration Record (MAR) books were observed to be closed and/or confidential information was covered.

The facility's grievance files and resident council minutes did not reveal that confidentiality was an issue.

Three nurses were interviewed regarding what they did with the MAR when they were not working with them, and they said they close the book or cover the information to protect residents' privacy.

The Director of Nursing was interviewed regarding how nurses use the MAR, and she said when the nurses are not in the immediate area and/or using the MAR, the nurses are trained to keep them closed or to cover them up. She also said she will watch nurses to make sure the MAR is closed or covered up.

James H. Hayes, Administrator
May 13, 2014
Page 7 of 7

Based on observations, records reviewed and staff interviews, the allegation could not be verified.

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 slanted.

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

LKK/dmj