



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

G.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 1659**

May 14, 2014

Daniel M. Mata, Temporary Administrator  
Saint Alphonsus Transitional Rehabilitation Unit  
1055 North Curtis Road  
Boise, ID 83706-1309

Provider #: 135119

Dear Mr. Mata:

On **April 30, 2014**, a Recertification and State Licensure survey was conducted at Saint Alphonsus Transitional Rehabilitation Unit 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 a widespread deficiency 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.

Daniel M. Mata, Temporary Administrator

May 14, 2014

Page 2 of 4

After each deficiency has been answered and dated, the administrator should sign both the Form CMS-2567 and State Form, Statement of Deficiencies and Plan of Correction in the spaces provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **May 27, 2014**. Failure to submit an acceptable PoC by **May 27, 2014**, may result in the imposition of civil monetary penalties by **June 16, 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

Daniel M. Mata, Temporary Administrator  
May 14, 2014  
Page 3 of 4

when determining your target date for achieving compliance.

- 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 **June 4, 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 **June 4, 2014**. A change in the seriousness of the deficiencies on **June 4, 2014**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **June 4, 2014** includes the following:

Denial of payment for new admissions effective **July 30, 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 30, 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

Daniel M. Mata, Temporary Administrator  
May 14, 2014  
Page 4 of 4

recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **April 30, 2014** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the noncompliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

<http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/NursingFacilities/tabid/434/Default.aspx>

go to the middle of the page to **Information Letters** section and click on **State** and select the following:

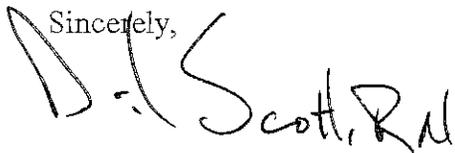
- BFS Letters (06/30/11)

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

This request must be received by **May 27, 2014**. If your request for informal dispute resolution is received after **May 27, 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: 05/13/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135119</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/30/2014</b>
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NAME OF PROVIDER OR SUPPLIER  <b>ST ALPHONSUS TRU</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1065 NORTH CURTIS ROAD BOISE, ID 83706</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	INITIAL COMMENTS  The following deficiencies were cited during the annual Federal recertification survey of your facility.  The surveyors who conducted the survey were: Linda Kelly, RN, Team Leader, and Susan Gollobit, RN.  The survey team entered the facility on Monday, April 28, 2014 and exited the facility on Wednesday, April 30, 2014.  Survey Definitions: ADL = Activities of Daily Living CNA = Certified Nurse Aide DON = Director of Nursing MDS = Minimum Data Set assessment	F 000	<p><b>RECEIVED</b></p> <p><b>JUN 04 2014</b></p> <p><b>FACILITY STANDARDS</b></p>	
F 226 SS=E	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 staff interview and review of the facility's policies to prevent abuse, it was determined the protection of residents during abuse investigations was not fully addressed. This had the potential to affect all sample residents (#'s 1 - 7) and most other residents in the facility. The lack of a comprehensive abuse policy created the potential for more than minimal	F 226		F 226 Corrective action will be completed 6/15/14

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

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F 226	<p>Continued From page 1</p> <p>harm if residents were not protected while an abuse investigation was in process. Findings include:</p> <p>The facility's undated policy, "Abuse Prevention and Investigation of Allegations of Abuse, Skilled Nursing Unit," documented, "...Investigations of Allegations of Abuse: ...The facility will prevent further potential abuse while the investigation is in progress. This may include reassignment or suspension of associates at the discretion of the administrator or designee..."</p> <p>On 4/30/14 at 10:40 a.m., The Administrator was asked how residents were protected during abuse investigations. The Administrator stated, "Our practice is to suspend the accused." When asked to read the aforementioned section of the abuse policy, the Administrator stated, "It should say suspension, not reassignment."</p> <p>On 4/30/14 at about 11:20 a.m., the Administrator provided 2 more policies on abuse. One of them, "Abuse of Patient - Allegations Involving Staff policy," dated 4/06, documented, "... E. Protection of the Patient During the Investigation 1. If the report involves an accusation of a physical, sexual or violent nature or there is any perception of threat to the patient, the staff member will be suspended immediately (without prejudice and pending a full investigation). 2. If the accusation is verbal in nature and does not have elements of physical, sexual, abuse or violence, the clinical coordinator (in consultation with the nurse manager or charge nurse) will have the discretion to suspend or reassign the staff member to other patients..."</p> <p>On 4/30/14 at about 11:50 a.m., when asked</p>	F 226	<p><b>Continued from F 226</b></p> <p>3. The facility will ensure the abuse policy and procedures meet the seven required components: screening, training, prevention, identification, investigation, protection and reporting/response.</p> <p>4. The abuse policy will be reviewed and changed to meet requirements by: The Administrator, The Director of Nurses, and The Statistical and Compliance Nurse Coordinator by 6/01/14. After the policy is reviewed and corrected, an in-service will be provided to all employees for re-education purposes by the Statistical and Compliance Nurse by 06/15/14. Compliance will be tracked by a sign-in sheet. Compliance will be reported to the Quality Assurance Committee. New employees will receive the revised abuse policy and procedure. Yearly policy review will be done by Quality Assurance Committee. Mandatory yearly in-service review of policy and procedures by all employees will also required.</p> <p>a) Administrator will monitor policy review and correction, as well as the</p>		

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F 226	Continued From page 2 about the aforementioned abuse policy, the Administrator acknowledged this policy also documented that suspension was an option. The Administrator reiterated that the facility's policy was to "suspend, not reassign" staff during abuse allegation investigations.  Note: Federal guidance at F 226 documented, "The facility must develop and operationalize policies and procedures for screening and training employees, protection of residents and for the prevention, identification, investigation, and reporting of abuse, neglect, mistreatment, and misappropriation of property. The purpose is to assure that the facility is doing all that is within its control to prevent occurrences. The facility must develop and implement policies and procedures that include the seven components: screening, training, prevention, identification, investigation, protection and reporting/response."  The facility did not provide any other information regarding the issue.	F 226	<b>Continued from F 226</b>  yearly review of policy and procedure by Quality Assurance Committee and all employees.  b) Monitoring will take place 1 X month during 3 months.  c) Audits will start 05/01/2014  5. Corrective action will be completed by 6/15/14, and auditing will be completed by 8/31/2014.	
F 248 SS=E	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES  The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.  This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident review, record review, and Facility Activity	F 248	<b>F 248-</b>  1. All sampled residents have discharged.  2. All future patients have potential to be affected by not providing an ongoing activity program to meet the resident's interests in accordance with their comprehensive assessment. The facility will screen all other residents to make sure an on-going activity program is present. Facility will initiate an ongoing activity program for all residents.  3. Facility will assess all residents to	<b>F 248</b>  Corrective action will be completed by 6/15/14

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F 248	<p>Continued From page 3</p> <p>Calendar review, it was determined the facility failed to provide an adequate and individualized Activity program for 3 (#2, #3, #5) of 7 sampled residents. The deficient practice had the potential to cause more than minimal harm when the facility did not provide an ongoing activity program to meet residents interests in accordance with their comprehensive assessment. Residents #2, #3, and #5 had identified activities which they enjoyed and were important to them, and the facility did not have an Activity program to provide activities of interest to the residents. Resident #2, #3, and #5 did not have activity care plans to inform staff of their interests. Findings included:</p> <p>The facility's Recreation Therapy Calendar dated April, 2014, documented: *Sundays and Mondays: blank. *Tuesdays: "Pet Therapy 10:00 a.m.-12:00 p.m. and 2:00-3:00 p.m. (As Available)" *Wednesdays: "Pet Therapy 10:00 a.m.-12:00 p.m. (as Available), Aquatic Therapy 2:00-4:00 p.m. STARS" *Thursdays: "Pet Therapy 2:00-3:00 p.m. (As Available), OT/Rec[Occupational / Recreational therapy] Group 3W DR 11:10 a.m.-12:00 p.m." Fridays: "Pet Therapy 1:30-2:00 p.m. (As Available.)" Saturdays: "Pet Therapy 10:00 a.m.-12:00 p.m. (As Available)."</p> <p>1. Resident #5 was admitted to the facility on 4/7/14 with diagnoses which included, depression, hemiplegia, and cerebrovascular accident.</p> <p>The residents Admission MDS dated 4/22/14, documented:</p>	F 248	<p><b>Continued from F 248</b></p> <p>Identify the patient's interests and provide activities of their interests.</p> <p>4. Administrator will monitor the initiation and implementation of the activity program to verify the program is meeting the individual needs of patients by performing an assessment; develop and implement individual activity plan, plan activities in advance, plan group activities and document participation or refusal.</p> <p>a) The Administrator will monitor the implementation of the activity program</p> <p>b) Monitoring will take place 1 X week for 4 weeks, then 1 X month for 2 months.</p> <p>c) Audits will start 5/01/14</p> <p>5. Corrective action will be completed by 6/15/14 and auditing completed 8/31/14.</p>		

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F 248	<p>Continued From page 4</p> <p>*BIMS score: 15, cognition intact.</p> <p>*Preferences for Customary Routine and Activities:</p> <p>*Daily Preference for:</p> <ul style="list-style-type: none"> <li>- Animal / pets: "Somewhat important."</li> <li>-News: "Somewhat important."</li> <li>-Groups of people: "Very important."</li> <li>-Favorite activities: "Very important."</li> <li>-Outside good weather: "Very important."</li> <li>-Religious practices: "Very important."</li> </ul> <p>On 4/28/14 at 1:50 pm, the surveyor observed the resident sitting in her wheelchair in her room. The Television was on the news and the resident had 2 family members in the room with her. The surveyor asked the resident if she participated in the pet therapy activity that was provided by the facility. The resident stated, "No." The resident's sister in law stated, "No, she is scared of them," and demonstrated the resident was scared because they bite, touching the resident's forearm. The surveyor asked the resident if she was offered any activities that she liked to do by the facility and she stated, "No, therapy that's all, they say you have therapy and you have your own TV you can watch." The surveyor asked the resident if she liked to watch TV, and she stated, "News that's all." The resident stated, "I would like to be able to go outside. There is nothing on the weekends here."</p> <p>On 4/30/14 at 8:40 am, the surveyor observed the resident in her wheelchair in her room, with her husband. The TV was on. The surveyor asked the resident if she had therapy on the weekends. The resident stated, "No." The resident's husband stated, "She has 1 hour on Saturday and nothing on Sunday, it's a wasted day." The surveyor asked the resident if Sunday seemed like a long</p>	F 248			

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F 248	<p>Continued From page 5</p> <p>day with no activities, and the resident stated, "Yes, it is, it's a rest day."</p> <p>On 4/29/14 at 10:45 am, LN#3 Unit Supervisor, was asked by the surveyor who was in charge of the Activity program for the facility. LN#3 stated, "We have Recreational therapy, who are under the OT [Occupational Therapy] department. [Name of OT/Recreational Therapy Supervisor (OT/RT#5)] is the Supervisor for OT/ RT departments. OT takes care of most of the activities for these residents. We have tried several times in the past and it has been unsuccessful. I have been here for 11 years and we have tried it off and on, and it has not worked."</p> <p>On 4/30/14 at 9:05 am, LN#2 was asked by the surveyor which facility staff was responsible for the section of the MDS, daily preferences of Activities. The LN stated she asked the questions, and [OT/RT#5] department is the one who does Activities. LN #2 was asked by the surveyor if there was an Activity care plan for the resident which included the activities Resident #5 told the facility were important to her. LN#2 stated, "I don't think so." LN#2 reviewed the resident chart on the computer and stated there was, "No activity care plan." LN#2 was asked by the surveyor if the facility had provided any services for the resident's religious practices, which the resident told the facility were very important to her. LN#2 provided a Chaplain's visit note from the resident's stay in the hospital. The surveyor asked then verified the resident had not been visited by the chaplain while in the facility. The surveyor asked LN#2 if the MDS would trigger a CAA and a care plan would implemented. LN#2 stated, "The resident's</p>	F 248		

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F 248	<p>Continued From page 6</p> <p>preferences for Activities does not trigger an Activities CAA." The surveyor asked if any of the residents in the facility had a care plan implemented for Activities and she stated, "I can check everyone's but I can tell you they don't have one. I would be the one to do it."</p> <p>On 4/30/14 at 11:15 am, LN#2 verified the resident's chart did not have documented activities that the resident had attended.</p> <p>On 4/30/14 at 12:15 pm, the surveyor interviewed OT/RT #5. The surveyor stated you were identified by the facility as the Activity director, and OT/RT #5 stated, "I am, ok." The survey asked what activities were provided for the residents, and he stated, "The Certified Recreational Specialists primary involvement is getting people back into the community, particularly if the have had a significant change in their life before entering the hospital." The surveyor showed the Activity calendar provided by the facility and asked the OT/RT#5 what did the Recreational Therapy Specialist provide for the residents, and he stated, "It is ordered only on select patients. The physician will order that." The surveyor asked if not everyone will have it, and he stated "That's right, not on every patient." The OT/RT #5 stated the Activity Calendar was prepared the Recreational therapist.</p> <p>On 4/30/14 at 12:35, the surveyor asked [Recreational Specialist] RS#6 if she had developed the facility's Activity calendar and RS#6 stated it was a template that she generated. The surveyor asked what days of the week were the Recreational Therapists in the facility and she answered, "Monday through Friday." The surveyor showed Resident #5's</p>	F 248		

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NAME OF PROVIDER OR SUPPLIER  <b>ST ALPHONSUS TRU</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1055 NORTH CURTIS ROAD BOISE, ID 83706</b>		
(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 248	<p>Continued From page 7</p> <p>MDS for activity preferences, to RS#6 and asked her if she was involved in providing information for the MDS or a care plan for the resident, RS#6 stated, "No." The surveyor asked what the "OT/Rec Group," scheduled on Thursday of each week, provided to the residents. RS#6 stated, "We have not had it since we moved up stairs. We did do Easter eggs 2 weeks ago. In a way it is OT driven. They will call me and tell me what she has, like a group of men to do wood working, or a group for scrap booking, and then we do a group." The surveyor asked RS#6 what "Aquatic Therapy" scheduled on Wednesdays of each week, provided for the residents. RS #6 stated, "Aquatic therapy on the calendar is physician ordered only and it is a block away." The surveyor asked what "Pet Therapy" provided for the residents and she stated, "Pet Therapy use to be through our department but is now through the volunteers."</p> <p>2. Resident #3 was admitted to the facility on 4/15/14 with diagnoses which included, depression, anxiety disorder and post traumatic stress disorder.</p> <p>The resident's admission MDS dated 4/30/14 documented: *BIMS score: 14, cognition intact. *Preferences for Customary Routine and Activities: *Daily Preferences: -Have books, newspapers, and magazines to read: "Very important." -Animals/ pets: "Very Important." -News: "Very important." -Favorite activities: "Very Important." -Outside good weather: "Very important." -Religious practices: "Somewhat important."</p>	F 248		

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

PRINTED: 05/13/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135119</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>04/30/2014</b>
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F 248	<p>Continued From page 8</p> <p>On 4/28/14 at 1:15 pm, the surveyor observed the resident seated in a chair in his room. The surveyor asked if he had time to talk with the surveyor, the resident stated, "I have an appointment, could you come back a little later. Yes, I want to talk to you."</p> <p>On 4/28/14 at 4:00 pm the surveyor observed the resident seated in the dining room drinking coffee. The resident was asked by the surveyor if the facility had provided activities during his stay. The resident stated, "There really is not much going on. I mostly stay in my room. I like to read. I have read a couple books." The surveyor asked the resident if the facility had offered him any books or if there was a library from where he could get books. The resident stated, "No, but it would be nice if there was one. Oh I don't know maybe they have one. I brought 2 books with me, my son can bring me one too."</p> <p>On 4/30/14 at 9:05 am, the surveyor asked LN #2 if the facility had implemented an activity care plan for Resident #3 which included his interests, and whether books had been provided for the resident. LN#2 stated, "No I don't think so." At 9:25 am, with the surveyor present, LN#2 accessed the computer and verified the resident did not have an Activity Care Plan.</p> <p>On 4/30/14 at 1:30 pm, the Administrator was informed of the findings. No additional information was provided.</p>	F 248			

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

PRINTED: 05/13/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135119</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/30/2014</b>
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F 248	Continued From page 9  4. Resident #2 was admitted to the facility on 3/28/14 with multiple diagnoses which included right above the knee amputation, acute pain, and chronic cough.  The admission MDS dated 4/10/14 documented the resident's cognition was intact with a BIMS score of 15. It also documented the resident's Preferences for Customary Routine and Activities included: * have books, newspapers, and magazines to read: "Very important;" * animals/ pets: "Very Important;" * news: "Very important;" * favorite activities: "Somewhat Important;" * outside good weather: "Very important;" * religious practices: "Very important."  On 4/28/14 at 1:20 p.m., the resident was observed in her room playing a card game with two male visitors.  On 4/29/14 at about 10:00 a.m., when asked about activities in the facility, the resident stated, "I do my own thing." The resident said she was busy with therapy. She added, however, "But I love the pets when they come by." The resident said no one had told her anything about activities.  On 4/30/14 at 9:05 am, LN #2 was asked if the facility had implemented an activity care plan for the resident. LN #2 stated, "No I don't think so."  On 4/30/14 at 9:25 am, with two surveyors present, LN #2 reviewed the resident's electronic medical record on the computer. LN #2 stated	F 248		

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

PRINTED: 05/13/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135119	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  04/30/2014
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F 248	Continued From page 10 there was no Activity Care Plan for the resident.	F 248		
F 272 SS=E	483.20(b)(1) COMPREHENSIVE ASSESSMENTS  The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.  A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and	F 272	F 272-  1. Resident # 1 is still on the Subacute unit and is potentially affected by the non-compliant issue. A comprehensive assessment will be done for all residents, current and future, to assess the resident's functional capacity.  2. The records of all residents will be reviewed to ensure a comprehensive, accurate, standardized reproducible assessment is completed.  3. All patients, current and future will be fully assessed using the Resident Assessment Instrument. The assessment will be documented on the resident's chart. The appropriate use of safety related items will be based on the resident's assessment.	F 272  Corrective action will be completed by 6/15/14

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

PRINTED: 05/13/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135119	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  04/30/2014
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F 272	<p>Continued From page 11 Documentation of participation in assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and record review, it was determined the facility failed to ensure that bed/side rails and a torso positioning belt were assessed to determine if the residents were safe with the use of the devices, obtained consent for the devices, or reviewed the risks versus benefits of the devices with the residents. This was true for 4 of 5 sample residents (#s 1, 2, 4 and 5). This failure created the potential for more than minimal harm should a resident become entrapped in a bed/side rail or torso belt. Findings included:</p> <p>1. Resident #2 was admitted to the facility on 3/28/14, with multiple diagnoses which included right above the knee amputation, acute pain, and chronic cough.</p> <p>The resident's admission MDS, dated 4/10/14, documented: * intact cognition with a BIMS score of 15; * limited assistance of one person for bed mobility; and, * limited assistance of two or more people for transfers.</p> <p>A nurse assessment form for the resident, dated 3/28/14, documented: **Environmental Safety Measures: Adequate</p>	F 272	<p><b>Continued from F 272</b></p> <p>4. Administrator will monitor the initiation and implementation of the Comprehensive Assessments for all patients. Administrator will provide education about the need for a comprehensive assessment to Director of Nurses by 05/31/14 and Director of Nurses to the rest of nurses by 06/15/14. Administrator and Director of Nurses will monitor documentation in the resident's chart.</p> <p>a) The Administrator and Director of Nurses will monitor the implementation of Comprehensive Assessment for all patients.</p> <p>b) Monitoring will take place 1 X week for 4 weeks, then 1 X month for 2 months.</p> <p>c) Monitoring will began 5/01/14</p> <p>5. Corrective action will be completed by 6/15/14 and auditing completed 08/31/14</p>	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135119</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>04/30/2014</b>
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F 272	<p>Continued From page 12</p> <p>room lighting, Bed alarm on, Bed locked / low position, Call light within reach, Non-skid footwear use, Room free of clutter and trip hazards, Side rails up x2 of 4."          *Comment: "Safe use of side rails."</p> <p>On 4/28/14 at 3:20 pm, when asked for the assessment the facility used for bed/side rails, the DON stated, "Two or 3 years ago we were told by the surveyor to evaluate for the residents 2 side rails on the initial nurse assessment. They put the assessments of the safety rail on it. The top 2 rails have the bed control."</p> <p>On 4/29/14 at 9:50 a.m., the resident was observed seated on her electric wheelchair (w/c) next to her bed. The half bed/side rail on the left side of the bed was in the raised position at the time.</p> <p>On 4/29/14 at 9:55 a.m., CNA #11 was observed as she assisted the resident to transfer from the w/c to the bed using a slide board. After the transfer, the CNA raised the right half side rail on the bed.</p> <p>On 4/30/14 at 11:25 am, when asked for documentation of the resident's consent for the use of the side rails and evidence the resident was informed of the risks versus benefits for the bed/side rails use, LN#2 stated, "I know we don't have anything like that, but I will ask Risk Management."</p> <p>On 4/30/14 at about 2:30 p.m., the Administrator was informed of the issue. No other information was received from the facility regarding the issue.</p> <p>2. Resident #4 was admitted to the facility on</p>	F 272			

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

PRINTED: 05/13/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135119</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/30/2014</b>
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F 272	<p>Continued From page 13</p> <p>4/21/14, with multiple diagnoses which included status post right total hip replacement.</p> <p>The 5-Day MDS, dated 4/28/14, documented: * intact cognition with a BIMS score of 15; * limited assistance of one person for bed mobility and transfers.</p> <p>A nurse assessment form for the resident, dated 4/21/14, documented: *"Environmental Safety Measures: Other: Safe use of side rails."</p> <p>On 4/28/14 at 3:20 pm, when asked for the assessment the facility used for bed/side rails, the DON stated, "Two or 3 years ago we were told by the surveyor to evaluate for the residents 2 side rails on the initial nurse assessment. They put the assessments of the safety rail on it. The top 2 rails have the bed control."</p> <p>On 4/30/14 at 9:30 a.m., the resident was observed seated on the left side of the bed with an Occupational Therapist (OT) in attendance. At that time, the half side rail on the right side of the bed was in the raised position.</p> <p>On 4/30/14 at 11:25 am, when asked for documentation of the resident's consent for the use of the side rails and evidence the resident was informed of the risks versus benefits for the bed/side rails use, LN#2 stated, "I know we don't have anything like that, but I will ask Risk Management."</p> <p>On 4/30/14 at about 2:30 p.m., the Administrator was informed of the issue. No other information was received from the facility regarding the issue.</p>	F 272		

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

PRINTED: 05/13/2014  
FORM APPROVED  
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER  <b>ST ALPHONSUS TRU</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1055 NORTH CURTIS ROAD BOISE, ID 83706</b>		
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F 272	<p>Continued From page 14</p> <p>3. Resident #1 was admitted to the facility on 4/15/14 with diagnoses which included cerebrovascular accident, and hemiplegia.</p> <p>The resident's Admission MDS dated, 4/30/14 documented: *BIMS score: 15, cognition intact. *Bed Mobility: 3-3, Extensive, 2 person physical assistance. *ROM[range of motion]: Upper extremity-Impairment on one side. Lower Extremity-Impairment on one side.</p> <p>The resident's nurse assessment form dated 4/15/14, documented: **"Environmental Safety Measures: Adequate room lighting, Bed alarm on, Bed locked / low position, Call light within reach, Non-skid footwear use, Room free of clutter and trip hazards, Side rails up x2 of 4." *Comment: "safe use of side rails."</p> <p>On 4/28/14 at 12:06 pm, the surveyor observed the resident seated in her w/c [wheel chair] in the dining room. The resident had a velcro lap belt around her torso and the wheel chair.</p> <p>On 4/28/14 at 5:15 pm, the surveyor observed the resident seated in her w/c with the velcro lap belt in place.</p> <p>On 4/29/14 at 7:55 am, the surveyor observed the resident in bed with bilateral upper half side rails in the upraised position. LN#10 and LN#3 assisted the resident from the bed to her w/c. When the resident was positioned in her w/c the velcro lap belt was placed around the resident's torso and w/c. The surveyor asked whether she could take the strap off, the resident stated she</p>	F 272			

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

PRINTED: 05/13/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135119	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  04/30/2014
NAME OF PROVIDER OR SUPPLIER  ST ALPHONSUS TRU			STREET ADDRESS, CITY, STATE, ZIP CODE 1055 NORTH CURTIS ROAD BOISE, ID 83706	
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F 272	<p>Continued From page 15</p> <p>could and with her right hand she grabbed at the strap and pulled to release the velcro lap belt.</p> <p>On 4/29/14 at 8:20 am, the surveyor observed the resident seated in her w/c at the dining room table with the velcro lap belt positioned around her torso and w/c.</p> <p>On 4/29/14 at 10:30 am, the surveyor observed the resident in bed with bilateral half side rails in the up position.</p> <p>On 4/29/14 at 12:15 pm, the surveyor observed the resident seated in her w/c with the velcro lap belt positioned around her torso and w/c.</p> <p>On 4/28/14 at 2:45 pm, the surveyor asked LN#1 how the lap belt was assessed, and where the assessment would state the resident could release it. LN#1 stated, "They would type it under the restraint part of the assessment, that would say they can release the lap belt." When the surveyor asked if the resident had an order for the lap belt. LN#1 stated, "She would not have an order for it because it is not a restraint, so I believe we would not have to have an order for it." The surveyor asked LN#1 when the lap belt was initiated, and she stated, "We have no way of knowing when it was started. It's a nursing intervention." LN#1 looked on the computer for the assessment, and stated "I am not seeing it." The surveyor asked, if the lap belt was assessed for safety for the resident. LN#1 stated, "Correct(staff did not perform a safety assessment). It is not on the assessment." LN#1 agreed the resident should have an assessment for use and safety of the lap belt.</p> <p>On 4/28/14 at 3:20 pm, the surveyor asked the</p>	F 272		

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

PRINTED: 05/13/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135119</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/30/2014</b>
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F 272	<p>Continued From page 16</p> <p>DON for the facility's side rail assessment. The DON stated, "Two or 3 years ago we were told by the surveyor to evaluate for the residents 2 side rails on the initial nurse assessment. They put the assessments of the safety rail on it. The top 2 rails have the bed control."</p> <p>On 4/29/14 at 10:45 am, the surveyor asked LN #4 Unit Supervisor, if there was an assessment for the velcro lap belt in use for resident #1. LN#4 stated, "I don't think there is an assessment for the lap belt. I wouldn't have thought to do that. It came about when she had the fall and it was to remind her not to go forward. It is not being used as a restraint."</p> <p>On 4/30/14 at 8:24 am, the surveyor observed the resident seated in her w/c in the dining room. The velcro lap belt was positioned around the resident's torso and w/c.</p> <p>On 4/30/14 at 11:25 am, the surveyor asked LN#2 if the facility had a consent form for the use of the side rails, or a risks versus benefits form making the resident aware of the hazards of side rails. LN#2 stated, "I know we don't have anything like that, but I will ask Risk Management."</p> <p>4. Resident #5 was admitted to the facility on 4/7/14 with diagnoses which included depression, hemiplegia, and cerebrovascular accident.</p> <p>The residents Admission MDS dated 4/22/14, documented: *BIMS score: 15, cognition intact. *Bed Mobility: 3-3, Extensive, 2 person physical assistance. *ROM[range of motion]: Upper extremity-Impairment on one side. Lower Extremity-</p>	F 272		

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

PRINTED: 05/13/2014  
FORM APPROVED  
OMB NO. 0938-0391

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F 272	<p>Continued From page 17 Impairment on one side.</p> <p>The resident's nurse assessment form dated 4/7/14, documented: *"Environmental Safety Measures: Adequate room lighting, Bed alarm on, Bed locked / low position, Call light within reach, Non-skid footwear use, Room free of clutter and trip hazards, Side rails up x2 of 4, Other: safe to use side rails."</p> <p>On 4/28/14 at 1:55 pm, the surveyor observed LN#3 and CNA#8 assist the resident to bed. The resident was positioned in bed with the bilateral upper 1/2 side rails, and the lower left side rail in the up position. The surveyor asked the resident if she used the upper rails, and she stated, "I use them for moving at times." The surveyor asked the resident if she used the lower left 1/2 side rail, and she stated, "No, I never use it." The surveyor asked the resident why the 1/2 lower side rail was up, and the resident stated she didn't know. *[NOTE: The resident had been assessed as safe for 2 side rails, and 3 were in use. The resident didn't know why the 3rd rail was up.]</p> <p>On 4/28/14 at 2:40 pm, the surveyor observed the resident in bed with the bilateral upper 1/2 side rails and the lower left 1/2 side rail in the upraised position.</p> <p>On 4/28/14 at 2:15 pm, the surveyor asked LN#1 why the resident had side rails. LN#1 stated, "The side rails are for residents so they do not fall out of bed." The surveyor asked LN#1 if the facility had a document the resident signed that stated they wanted the side rails, she stated, "No." The surveyor asked if Physical Therapy was involved in the assessment of the side rails. LN#1 stated, "No, they are not. It's for their (residents) safety."</p>	F 272		

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

PRINTED: 05/13/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135119</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/30/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>ST ALPHONSUS TRU</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1055 NORTH CURTIS ROAD BOISE, ID 83706</b>	
(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 272	Continued From page 18 They are hospital rails. Everybody gets rails when they are admitted here."  On 4/30/14 at 11:25 am, the surveyor asked LN#2 if the facility had a consent form for the use of side rails, or a risks versus benefits form making the resident aware of the hazards of side rails. LN#2 stated, "I know we don't have anything like that, but I will ask Risk Management."  On 4/30/14 at 1:30 pm, the Administrator was informed of the findings. No additional information was provided.	F 272		
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS  A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.  The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.  The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279	F 279 -  1. Resident # 1 is still on the Subacute unit and is potentially affected by the non-compliant issue. The facility will develop a comprehensive care plan for all residents with measurable objectives and timetables to meet a resident's needs.  2. The record of all residents will be reviewed to ensure all patients have a comprehensive plan of care. The facility will develop a comprehensive plan of care for all residents.  3. All patients, current and future will be fully assessed using the Resident Assessment Instrument. The assessment will be documented on the resident's chart.	F 279  Corrective action will be completed by 6/15/14

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

PRINTED: 05/13/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135119	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  04/30/2014
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F 279	<p>Continued From page 19</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility failed to ensure care plans included the focus or problem area, goals, and interventions for each focus/problem area. This was true for 4 of 5 sample residents (#s 1, 2, 4, and 5). The failure created the potential for residents' needs to not be met due to lack of direction in their care plans. Findings included:</p> <p>1. Resident #2 was admitted to the facility on 3/28/14 with multiple diagnoses which included included right above the knee amputation, acute pain, and chronic cough.</p> <p>The resident's admission MDS, dated 4/10/14, documented: * intact cognition with a BIMS score of 15; * limited assistance of one person for bed mobility; and, * limited assistance of two or more people for transfers.</p> <p>The resident's Plan of Care summary was provided to the surveyor on 4/28/14. It did not include the use of side rails or include the focus/problem, goals, or interventions.</p> <p>On 4/29/14 at 9:50 a.m., the half bed/side rail on the left side of the resident's bed was observed in the raised position. And, at 9:55 a.m., after the resident transferred into bed, both the left and the right half side rails were observed in the raised position.</p> <p>On 4/30/14 at 2:20 p.m., LN #2 reviewed the resident's electronic medical record on the</p>	F 279	<p><b>Continued from F279</b></p> <p>The facility will use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>4. Administrator will provide education about the need for a comprehensive assessment to Director of Nurses by 05/31/14 and Director of Nurses to the rest of nurses by 06/15/14. Administrator and Director of Nurses will monitor documentation in the resident's chart.</p> <p>a) The Administrator and Director of Nurses will monitor the implementation of developing a comprehensive care plan</p> <p>b) Monitoring will take place 1 X week for 4 weeks, then 1 X month for 2 months.</p> <p>c) Monitoring will began 5/01/14</p> <p>5. Corrective action will be completed by 6/15/14 and auditing completed 08/31/14</p>

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

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OMB NO. 0938-0391

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F 279	<p>Continued From page 20</p> <p>computer with two surveyors present. When asked if the resident's care plan included the use of half bed/side rails, LN#2 stated "No, nothing specific." When asked if the resident's care plan documented focus or problems areas, goals, and interventions or approaches, LN #2 stated, "No."</p> <p>On 4/30/14 at about 2:30 p.m., the Administrator was informed of the issue. No other information was received from the facility regarding the issue.</p> <p>2. Resident #4 was admitted to the facility on 4/21/14, with multiple diagnoses which included status post right total hip replacement.</p> <p>The resident's 5-Day MDS, dated 4/28/14, documented: * intact cognition with a BIMS score of 15; * limited assistance of one person for bed mobility and transfers.</p> <p>The resident's Plan of Care Summary was provided to the surveyor on 4/28/14. It did not include the use of side rails or include the focus/problem, goals, or interventions.</p> <p>On 4/30/14 at 9:30 a.m., the resident was observed seated on the left side of the bed with an Occupational Therapist (OT) in attendance. At that time, the half side rail on the right side of the bed was in the raised position.</p> <p>On 4/30/14 at 2:30 p.m., LN #2 reviewed the resident's electronic medical record on the computer with two surveyors present. When asked if the resident's care plan included the use of half bed/side rails, LN#2 stated "No, nothing specific." When asked if the resident's care plan documented focus or problems areas, goals, and</p>	F 279		

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

PRINTED: 05/13/2014  
FORM APPROVED  
OMB NO. 0938-0391

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F 279	<p>Continued From page 21 interventions or approaches, LN #2 stated, "No."</p> <p>On 4/30/14 at about 2:30 p.m., the Administrator was informed of the issue. No other information was received from the facility regarding the issue.</p> <p>3. Resident #1 was admitted to the facility on 4/15/14 with diagnoses which included cerebrovascular accident and hemiplegia.</p> <p>The resident's nurse assessment form, dated 4/15/14, documented: **"Environmental Safety Measures: Adequate room lighting, Bed alarm on, Bed locked / low position, Call light within reach, Non-skid footwear use, Room free of clutter and trip hazards, Side rails up x2 of 4." *Comment: "safe use of side rails."</p> <p>The resident's Plan of Care summary was provided to the surveyor on 4/28/14. The plan of care did not have a lap belt or the use of side rails documented with a focus, a goal or as an intervention.</p> <p>On 4/28/14 at 12:06 pm, the surveyor observed the resident seated in her w/c [wheel chair] in the dining room. The resident had a velcro lap belt around her torso and the wheel chair.</p> <p>On 4/28/14 at 5:15 pm, the surveyor observed the resident seated in her w/c, with the velcro lap belt in place.</p> <p>On 4/29/14 at 7:55 am, the surveyor observed the resident in bed with bilateral, upper half side rails in the up position. LN#10 and LN#3 assisted the resident from the bed to her w/c. When the resident was positioned in her w/c the velcro lap</p>	F 279			

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

PRINTED: 05/13/2014  
FORM APPROVED  
OMB NO. 0938-0391

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F 279	<p>Continued From page 22 belt was placed around her torso and w/c.</p> <p>On 4/29/14 at 8:20 am, the surveyor observed the resident seated in her w/c at the dining room table with the velcro lap belt positioned around the her torso and w/c.</p> <p>On 4/29/14 at 10:30 am, the surveyor observed the resident in bed with bilateral half side rails in the upraised position.</p> <p>On 4/29/14 at 12:15 pm, the surveyor observed the resident seated in her w/c with the velcro lap belt positioned around her torso and w/c.</p> <p>On 4/30/14 at 8:24 am, the surveyor observed the resident seated in her w/c in the dining room with the velcro lap belt positioned around her torso and w/c.</p> <p>On 4/30/14 at 2:05 pm, the surveyor asked LN#2 if the resident's care plan documented the use of the lap belt and the 1/2 side rails. LN#2 stated "No, nothing specific."</p> <p>4. Resident #5 was admitted to the facility on 4/7/14 with diagnoses which included depression, hemiplegia, and cerebrovascular accident.</p> <p>The resident's nurse assessment form dated 4/15/14, documented: **Environmental Safety Measures: Adequate room lighting, Bed alarm on, Bed locked / low position, Call light within reach, Non-skid footwear use, Room free of clutter and trip hazards, Side rails up x2 of 4." *Comment: "safe use of side rails."</p> <p>The resident's Plan of Care summary was</p>	F 279		

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

PRINTED: 05/13/2014  
FORM APPROVED  
OMB NO. 0938-0391

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F 279	Continued From page 23 provided to the surveyor on 4/28/14. The plan of care did not document the use of side rails with a focus, a goal or as an intervention.  On 4/28/14, at 1:55 pm, the surveyor observed LN#3 and CNA#8 assist the resident to bed. The resident was positioned in bed with the bilateral upper 1/2 side rails, and the lower left side rail in the up position.  On 4/28/14 at 2:40 pm, the surveyor observed the resident in bed, the bilateral upper 1/2 side rails, and the lower left 1/2 side rail, were in the up position.  On 4/30/14 at 2:05 pm, the surveyor asked LN#2 if the residents care plan documented the use of the 1/2 side rails by the resident. LN#2 stated "No, nothing specific."  On 4/30/14 at 1:30 pm, the Administrator was informed of the findings. No additional information was provided.	F 279			
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	F 280	<b>F 280 --</b>  1. Resident # 1 is still on the Subacute unit and is potentially affected by the non-compliant issue. The facility will develop a comprehensive care plan for all residents with measurable objectives and timetables to meet a resident's needs and include the resident, the resident's representative to participate in the planning. The facility will provide to patients and their family an opportunity to express their concerns and desires for the care they would receive.	<b>F 280</b>  Corrective action will be completed by 6/04/14	

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

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FORM APPROVED  
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F 280	<p>Continued From page 24</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview and record review, it was determined the facility failed to invite 3 of (#1, 3, 5) 7 sampled residents to participate in care plan conferences. The deficient practice had the potential to cause more than minimal harm when the facility did not involve residents in planning their own care. The resident's were not provided the opportunity to express their concerns and desires for the care they would receive. Findings included:</p> <p>1. Resident #5 was admitted to the facility on 4/7/14 with diagnoses which included depression, hemiplegia, and cerebrovascular accident.</p> <p>The residents Admission MDS dated 4/22/14, documented: *BIMS score: 15, cognition intact.</p> <p>On 4/28/14 at 1:50 pm, the surveyor asked the resident if the facility invited her to care meetings conducted to provide care for her. The resident stated, "No, I haven't been invited. They should invite the patient and the family. They tell my husband but not me what the plans are. They call him at work. I think they have another meeting tomorrow."</p>	F 280	<p><b>Continued from F 280</b></p> <p>2. The record of all residents will be reviewed to ensure all patients and their families have had an opportunity to express their concerns and desires for the care they would receive. The facility will include patients, their family and their representatives in the participation of the care planning and they will have an opportunity to express their concerns and desire for the care they would receive.</p> <p>3. All patients, current and future will receive an invitation from the interdisciplinary team for care plan planning and review participation. The invitation, planning and review participation will be documented on the resident's chart.</p> <p>4. Administrator will monitor the invitation of residents, families and/or their representatives to participate on the resident's planning of the care plan. Administrator will provide education to the interdisciplinary team regarding patient's participation for their care plan by 06/01/14.</p>	

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

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F 280	<p>Continued From page 25</p> <p>On 4/29/14 at 10:45 am, the surveyor asked LN#4 to describe the process for care conferences in the facility. LN#4 stated, "We do not generally involve the resident in care plan meetings. If we involve the resident or the family we have to plan that out differently. We conference once a week. We identify the goals for the resident. Each discipline gets 15 minutes at the round table. The disciplines involved are the MD [Medical Doctor], SW [Social Worker], OT [Occupational therapist], PT [Physical Therapist], ST [speech Therapist], and Nursing. Everybody involved in her care. We discuss and identify the care plan needs. If it is determined the resident wants to be involved we schedule a care conference with them. The SW will talk to the resident and tell them what was discussed in the weekly conference. The need for the resident to be involved is not there." The surveyor asked LN#4 if the facility had documentation that they had provided the resident the opportunity to participate in their own plan of care. LN #4 stated, "I can tell you I do not have that."</p> <p>On 4/30/14 at 8:40 am, the surveyor asked the resident if the facility staff had talked to her about a care conference or the plans for her. The resident stated, "No, I think they talked to him, but not me." The resident had pointed to her husband who was also in the room.</p> <p>On 4/29/14 at 10:45 am, the surveyor asked LN#4 the process for care conferences in the facility. LN#4 stated, "We do not generally involve the resident in care plan meetings. If we involve the resident or the family we have to plan that out differently. We conference once a week. We identify the goals for the resident. Each discipline</p>	F 280	<p><b>Continued from F 280</b></p> <p>a) The Administrator will monitor the implementation of inviting patients, their families and /or their representatives for the care they would receive.</p> <p>b) Monitoring will take place 1 X week for 4 weeks, then 1 X month for 2 months.</p> <p>c) Monitoring will began 5/01/14</p> <p>5. Corrective action will be completed by 6/04/14 and auditing completed 08/31/14</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 280	<p>Continued From page 26</p> <p>gets 15 minutes at the round table. The disciplines involved are the MD [Medical Doctor], SW [Social Worker], OT [Occupational therapist], PT [Physical Therapist], ST [speech Therapist], and Nursing. Everybody involved in her care. We discuss and identify the care plan needs. If it is determined the resident wants to be involved we schedule a care conference with them. The SW will talk to the resident and tell them what was discussed in the weekly conference. The need for the resident to be involved is not there." The surveyor asked LN#4 if the facility had documentation that they had provided the resident the opportunity to participate in the resident's plan of care. LN #4 stated, "I can tell you I do not have that."</p> <p>2. Resident #3 was admitted to the facility on 4/15/14 with diagnoses which included depression, anxiety disorder and post traumatic stress disorder.</p> <p>The resident's admission MDS dated 4/30/14 documented: *BIMS score: 15, cognition intact.</p> <p>On 4/28/14 at 4:00 pm, the resident stated to the surveyor, "I am suppose to be going home tomorrow, but I am not sure because of my medications. they are working on where I will get them." The surveyor asked the resident if the facility had invited him to his care conferences. The resident stated, "No, I haven't been asked to any care conference. They keep telling me that is next."</p> <p>On 4/29/14 at 10:26 am, the resident stated to the surveyor, "I think I am going home today." The surveyor asked the resident if the facility had</p>	F 280		

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

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F 280	Continued From page 27 talked to him that morning about going home. The resident stated, "Yes, off and on."  3. Resident #1 was admitted to the facility on 4/15/14 with diagnoses which included cerebrovascular accident, and hemiplegia.  The resident's Admission MDS dated, 4/30/14 documented: *BIMS score: 15, cognition intact.  On 4/29/14 at 10:45 am, the surveyor asked LN#4 if the facility had invited the resident to a care conference. LN#4 stated, "The family had requested a conference for her and we have set one up." The surveyor asked LN#4 to describe the process for care conferences in the facility. LN#4 stated, "We do not generally involve the resident in care plan meetings. If we involve the resident or the family we have to plan that out differently."  On 4/30/14 at 1:30 pm, the Administrator was informed of the findings. No additional information was provided.	F 280		
F 364 SS=D	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP  Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.  This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews, and test	F 364	<b>F 364</b>  1. 1.All sampled residents have discharged.  2. All future patients have potential to be affected by not receiving food prepared that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. The facility will ensure that all food served is palatable, attractive, and at the proper temperature as determine by the type of food to ensure resident's satisfaction.	<b>F 364</b> Corrective action will be completed by 6/01/14

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

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F 364	<p>Continued From page 28</p> <p>tray results, it was determined the facility failed to prepare and serve palatable food. This was true for 2 of 5 sample residents (#s 4 and 6). Foods that were not hot when they should have been and milk that was not cold created the potential for more than minimal harm if residents did not enjoy good quality of life and have their nutritional needs met because of unpalatable food. Findings included:</p> <ol style="list-style-type: none"> <li>1. On 4/28/14 at about 9:20 a.m., during an initial tour of the facility with LN #1 in attendance, when asked about the food served in the facility, Resident #6 stated, "The food is cold and not appetizing. It's the soup and coffee."</li> <li>2. On 4/28/14 at 1:20 p.m., when asked about food served in the facility, Resident #4 stated, "Everything I ordered hot was cold." The resident said that soup and coffee, in particular, were "not hot" when she got them.</li> <li>3. On 4/29/14 at 12:15 p.m., a test tray of the lunch meal was evaluated by the dietary Patient Care Services Manager (PCSM) and 2 surveyors. The PCSM used a kitchen thermometer to obtain the temperatures of the food items.</li> </ol> <p>The test tray evaluation revealed: * The temperature of a bowl of vegetable soup was 125.2 degrees F (Fahrenheit). The soup was warm, it was not hot. The PCSM stated, "I think it's warm. I think it is hot enough." However, when informed both surveyors did not find the soup to be "hot enough," the PCSM did not disagree. * The temperature of a cup of coffee was 139.8 degrees F. The coffee was warm, it was not hot. The PCSM stated, "It's okay, for the temperature."</p>	F 364	<p><b>Continued from F364</b></p> <ol style="list-style-type: none"> <li>3. The facility will take the following measures: Soup will be dished into serving vessels as close to the service time as possible. Coffee will be poured from an insulated server to the resident's cup on the nursing unit, immediately prior to serving the resident their tray. Milk will be stocked to the air curtain cooler on the serving line as close to service time as is possible, and will be stocked in smaller quantities, thus allowing it to remain as cold as possible for as long as possible. A tray assessment process will be conducted to verify that food temperatures, taste and appearance are meeting standards.</li> <li>4. The Food and Nutrition Services Director will monitor the new processes implemented in the kitchen area to ensure resident's satisfaction.             <ol style="list-style-type: none"> <li>a) The Food and Nutrition Services Director will monitor the soup, coffee, milk and tray process.</li> <li>b) Monitoring will be conducted weekly X 4, then q2 weeks X 4, then 1 X month for 2 months. Shift Leads and/or Patient Care Services Manager will monitor resident meal satisfaction beginning 5/01/14</li> </ol> </li> </ol>		

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

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F 364	Continued From page 29 * The temperature of a carton of milk was 51.8 degrees F. The milk was cool, it was not cold. The PCSM stated, "It's cool but not ice cold.  The intent of §483.35(d) is that, "Food should be palatable, attractive, and at the proper temperature as determined by the type of food to ensure resident's satisfaction."  On 4/30/14 at about 1:30 p.m., the Administrator was informed of the food palatability. The facility did not provide any other information regarding the issue.	F 364	<b>Continued from F364</b>  and will be conducted weekly X 4, then q2 weeks X 4, then 1 X month for 2 months.  c) Monitoring will began 5/01/14  5. Corrective action will be completed by 6/01/14 and auditing completed 08/31/14	
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions  This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure food items in the Cook's cooler were covered, dated, and not outdated. The facility also failed to ensure beard and hair restraints were worn while staff were in the cooking areas of the kitchen. These failures affected 7 of 7 (#s 1-7) sample residents and had the potential to affect all residents who ate food prepared in the kitchen. This practice created the	F 371	<b>F 371 -</b>  1. Resident # 1 is still on the Subacute unit and is potentially affected by the non-compliant issue. The facility will correct the store, preparation and service of food procedures to meet Federal, State and local guidelines.  2. All patients, current and future have the potential to be affected by not storing, preparing and distributing food under sanitary conditions. The Food and Nutrition Services Director will perform an in-service training to all the kitchen production personnel regarding expired products, food code policy, dating perishable food items, hair and beard restraints policy by 06/01/14.	F 371  Corrective action will be completed by 6/01/14

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F 371	<p>Continued From page 30 potential for contamination of food and exposed the residents to potential sources of pathogens. Findings included:</p> <p>1. On 4/28/14 at about 8:40 a.m., during an initial tour of the kitchen with the Director of Food Services (DFS) in attendance, the following was observed in the Cook's cooler: * a container of red sauce with an expiration date of 4/25/14; * a large plastic container of uncovered taco meat; and, * no date on an approximately 6 inch long sliced pepperoni wrapped in plastic.</p> <p>Regarding the red sauce, the DFS stated, "Yes, it should have been gone the 25th." Regarding the uncovered taco meat, the DFS initially said, "It's cooling" then he stated, "That's from late night." The DFS verified that the pepperoni was not dated.</p> <p>On 4/28/14 at about 5:20 p.m., the Administrator and LN #2 were informed of the outdated, uncovered, and undated food items observed in the kitchen. The facility did not provide any other information regarding the issue.</p> <p>2. Note: The 2009 FDA Food Code, Chapter 2, Part 2-4, Hygiene Practices, Hair Restraints, subpart 402.11, Effectiveness, indicates, "(A) Except as provided in ¶ (B) of this section, food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food; clean equipment, utensils, and linens; and unwrapped single-service and single-use articles. (B) This</p>	F 371	<p><b>Continued from F 371</b></p> <p>3. The Food and Nutrition Services Director will provide a mandatory training to all kitchen production personnel regarding store, prepare, serve – sanitary policies by 06/01/14.</p> <p>4. Mandatory in-service training documentation. Daily compliance monitor compliance (hair restraints) and weekly quality assurance monitor.</p> <p>a) The Administrator will monitor the mandatory training compliance and the quality assurance compliance.</p> <p>b) Monitoring will be conducted weekly X 4, then q2 weeks X 4, then 1 X month for 2 months.</p> <p>c) Monitoring will began 5/01/14</p> <p>5. Corrective action will be completed by 6/01/14 and auditing completed 08/31/14</p>	

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F 371	<p>Continued From page 31</p> <p>section does not apply to food employees such as counter staff who only serve beverages and wrapped or packaged foods, hostesses, and wait staff if they present a minimal risk of contaminating exposed food; clean equipment, utensils, and linens; and unwrapped single-service and single-use articles."</p> <p>a) On 4/28/14 at about 8:55 a.m., during an initial tour of the kitchen with the dietary Patient Care Services Manager (PCSM) in attendance, Dietary Cook #7, who had a full beard, was observed cooking in the kitchen. The Cook's facial hair was approximately 1/2 to 3/4 inches in length. The Cook's beard was not restrained. The PCSM agreed the Cook's beard was not restrained.</p> <p>Cook #7 was immediately asked about his unrestrained beard. The Cook confirmed his beard was not restrained and indicated he would obtain a beard restraint right away.</p> <p>At about 9:00 a.m., the Chef joined the conversation. The Chef said it was his understanding that if the hair length was less than "half the length of the little fingernail" the beard did not have to be restrained. However, when informed that fingernails come in different lengths, the PCSM and the Chef both agreed that the length of one person's little fingernails can vary greatly from another person's little fingernails.</p> <p>Later that day, the Director of Food Services (DFS) said it was his understanding that facial hair did not have to be restrained if it was close shaven and well groomed and that Cook #7's beard was close shaven and well groomed.</p>	F 371		

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F 371	Continued From page 32 b) On 4/29/14 at about 11:50 a.m., the PCSM, who had a full head of hair, was observed as he walked through the oven and grill section of the kitchen without a hair restraint. Staff were cooking in the area at the time. The PCSM's hair length was approximately 1 inch to 1 and 1/2 half inches in length. The PCSM confirmed his hair was not restrained when he walked through the area. The PCSM said he was on his way to get a hairnet.  At about 12:00 p.m. that day, the DFS was informed of the observation. The DFS said it was his understanding that hair restraints applied only when staff were actually cooking or serving food.  On 4/28/14 at about 5:20 a.m., the Administrator and LN #2 were informed of the unrestrained beard issue. On 4/30/14 at about 1:30 p.m., the Administrator was also informed of the unrestrained hair observation. The facility did not provide any other information on the issue.	F 371			
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective	F 441	<b>F 441 -</b>  1. Resident # 1 is still on the Subacute unit and is potentially affected by the non-compliant issue. The facility will effectively maintain an Infection Control Program to help prevent the development and transmission of disease and infection.  2. Director of Nurses and/or Infection Control personnel will observe nurses and CNAs while providing care to make sure good hand hygiene and equipment storage is done for all residents.	<b>F 441</b>  Corrective action will be done 5/15/14	

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F 441	<p>Continued From page 33 actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility failed to: cover and/or properly store resident use items (a bedpan, collection hat, and heating pad) off the floor or another potentially contaminated surface; or, remove used gloves and perform hand hygiene after toileting assistance. This was true for 3 of 7 sample residents (#s 1, 4, and 5). Failure to implement infection control measures placed the residents at increased risk to develop infections. Findings included:</p> <p>1. On 4/28/14 at 9:40 a.m., during an initial tour of the facility with LN #1 in attendance, the following</p>	F 441	<p><b>Continued from F 441</b></p> <p>The monitoring observations will take place two days a week starting 06/01/14 until 8/31/14</p> <p>Infection Control representative and Director of Nurses will in-service all nursing staff on: isolation precautions, preventing spread of infection, hand washing, communicable disease prevention, hand hygiene and equipment storage by 06/15/14.</p> <p>3. The facility's Infection Control Program will provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>a) The Director of Nurses will monitor the in-service training and the observance of good infection control habits by the nursing staff.</p> <p>b) Monitoring for in-service training will be 2 X month for 2 months.</p> <p>c) Monitoring will began 5/01/14</p> <p>5. Corrective action will be completed by 06/15/14 and auditing completed by 8/31/14</p>	

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F 441	<p>Continued From page 34</p> <p>was observed in Resident #1's bathroom: * an uncovered bedpan was turned upside down on top of the trash can; and, * an uncovered collection hat (used to collect urine or stool samples) was on the floor.</p> <p>LN #1 was immediately asked about the bedpan and collection hat. Regarding the bedpan, the LN stated, "Usually there's a basket on the wall with a plastic liner and they are in there." The LN indicated she would have a staff member clean the bedpan and place it in a plastic bag. Regarding the collection hat, the LN stated, "It should not be on the floor" as she placed it under the seat on the toilet.</p> <p>LN #1 asked Resident #1 if she used the bedpan. The resident stated, "Yes, mostly at night."</p> <p>On 4/30/14 at about 1:30 p.m., the Administrator was informed of the observation. The facility did not provide any other information about the bedpan or collection hat.</p> <p>2. On 4/28/14 at about 1:20 p.m., Resident #4 was observed seated in a chair next to her bed. A heating pad and the heating pad machine were observed on the floor between the chair and bed. The heating pad was draped over the machine and both ends of the heating pad touched the floor. The heating pad machine was turned on.</p> <p>When asked if she used the heating pad, the resident said she had not used it for "4 days."</p> <p>At 1:30 p.m., LN #3 accompanied the surveyor to Resident #4's room. When asked about the heating pad/machine on the floor, the LN stated,</p>	F 441			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 441	<p>Continued From page 35</p> <p>"It's a heating pad." The LN turned off the heating pad machine then folded the pad and placed it under the machine's handle. The LN stated, "It [the heating pad] was on the floor and it shouldn't be." When asked if the heating pad machine was turned on, the LN stated, "Yes, it was on."</p> <p>On 4/30/14 at about 1:30 p.m., the Administrator was informed of the observation. The facility did not provide any other information about the heating pad on the floor.</p> <p>*Resident #5 was admitted to the facility on 4/7/14 with diagnoses which included depression, hemiplegia, and cerebrovascular accident.</p> <p>On 4/28/14 at 1:55 pm, the surveyor observed LN#3 and CNA#8 provide pericare for the resident, both staff had gloves on. The resident was transferred to a commode chair, where she voided. The resident was then assisted to stand. LN#3 stood in front of the resident and wiped the resident's peri area front to back. While still wearing the contaminated gloves, LN#3 then pulled up the resident's pants and assisted to positioning her in her wheelchair. LN#3, still wearing the contaminated gloves, then removed the commode bucket, opened the bathroom door, and cleaned out the bucket. LN #3 put the cleaned bucket back in the commode chair, removed the contaminated gloves and washed her hands. The surveyor asked LN#3 if she should have taken the gloves off after she provided the pericare, before she touched the resident's clothes, wheelchair and bathroom door with contaminated gloves. LN#3 agreed she</p>	F 441			

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F 441	Continued From page 36 should have changed her gloves after the pericare.  On 4/30/14 at 1:30 pm, the Administrator was informed of the findings. No additional information was provided.	F 441		
F 468 SS=F	483.70(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS  The facility must equip corridors with firmly secured handrails on each side.  This REQUIREMENT is not met as evidenced by: Based on observation and staff interview it was determined the facility failed to ensure 7 of 7 (#1, 2, 3, 4, 5, 6, 7) sampled residents, and any resident accessing the hallways throughout the Transitional Rehab unit, were provided with handrails. Throughout the Transitional Rehab unit, the hallways had random areas without handrails. Findings included:  On 4/30/14, at approximately 11:00 am, the surveyor observed the hallways throughout the unit. *On the resident room side of the hall there were no handrails from the Physical Therapy room, past resident rooms, past the Fire doors and past room 4433. There were wall spaces in length from approximately 3 feet up to approximately 6 feet with no handrails. * On the opposite side of the resident rooms, there were random areas of wall space with no handrails. The wall space from the supply room to the nurses station and nurses station to the dining room did not have handrails. The wall space	F 468	F 468 –  1. Resident # 1 is still on the Subacute unit and is potentially affected by the non-compliant issue. The facility will add handrails to hallways.  2. All patients, current and future have the potential to be affected by not having handrails on each side. Handrails will be installed between each patient room door as the area will allow between rooms 4434-4444. This will give additional safety support at the most used patient areas first.  3. Handrails will be installed in the patient's areas by 6/15/14. Therapy staff will receive an in-service by the Therapy supervisors regarding the use of areas with proper handrails for therapy walks with patients by 06/04/14.  4. Handrails installation will be monitored by Administrator  a) Administrator will perform the monitoring  b) Monitoring will be done weekly X 1, then, q2 weeks, then monthly X 2 months	F 468  Corrective action will be completed by 06/15/14

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F 468	<p>Continued From page 37</p> <p>from the dining room, to the shower room, to the fire door did not have handrails. The wall spaces were up to approximately 5 feet.</p> <p>*The corridor across from the Physical therapy room, to the Fire doors had 3 random areas with no handrails.</p> <p>*The elevator corridor across from room 4433 had a sitting room with no handrails on either side of the openings to the room. The lengths of each wall without handrails were approximately 9 feet and approximately 4 feet respectively.</p> <p>*The corridor with Therapy offices, and Administrative offices had no hand rails on either side of the corridor from Easy Street Physical Therapy, to the Fire doors.</p> <p>On 4/30/14 at 10:55 am, the surveyor stated to the Safety officer and the Engineering officer the concerns of safety for the residents, regarding handrails in the Transitional Rehab unit. They both agreed it was a safety issue. The Engineering officer stated the handrails had been put up randomly.</p> <p>On 4/30/14 at 1:30 pm, the Administrator was informed of the findings. No additional information was provided.</p>	F 468	<p>Continued from F 468 -</p> <p>c) Monitoring will began 05/01/14.</p> <p>5. Corrective action will be completed by 6/15/14 *Handrails will need to be ordered to fill in the other areas noted in this report. Lead time will be 2 months for these areas to be completed. SNF AREA IS TEMPORARILY ON THE 4<sup>th</sup> FLOOR. SNF WILL BE BACK TO 3<sup>rd</sup> FLOOR BY 07/21/14 APPROXIMATELY WHEN REFRESH IS COMPLETED.</p>	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001680</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>04/30/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>ST ALPHONSUS TRU</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1055 NORTH CURTIS ROAD BOISE, ID 83706</b>		
(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 annual State licensure survey of your facility.  The surveyors who conducted the survey were: Linda Kelly, RN, Team Leader, and Susan Gollobit, RN.  The survey team entered the facility on Monday, April 28, 2014 and exited the facility on Wednesday, April 30, 2014.	C 000		
C 176	02.105.01 Personnel Policies  105. PERSONNEL.  01. Personnel Policies. Personnel policies shall be developed and implemented and shall include: This Rule is not met as evidenced by: Refer to F 226 as it related to abuse policies.	C 176	C 176 Please refer to F 226	
C 311	02.107.07 FOOD PREPARATION AND SERVICE  07. Food Preparation and Service. Foods shall be prepared by methods that conserve nutritive value, flavor and appearance, and shall be attractively served at proper temperatures. This Rule is not met as evidenced by: Refer to F 364 as it related to the palatability of the food.	C 311	C 311 Please refer to F 364	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

*David M. Jette*

*PERMS DIRECTOR/INF ADMINISTRATION*

*6-4-14*

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C 325	Continued From page 1	C 325		
C 325	02.107,08 FOOD SANITATION  08. Food Sanitation. The acquisition, preparation, storage, and serving of all food and drink in a facility shall comply with Idaho Department of Health and Welfare Rules, Title 02, Chapter 19, "Rules Governing Food Sanitation Standards for Food Establishments (UNICODE)." This Rule is not met as evidenced by: Refer to F371 as it related to sanitation in the kitchen.	C 325	C 325 Please refer to F 371	
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 which pertains to lack of handrails on the Transitional Rehab unit.	C 389	C 389 Please refer to F 468	
C 409	02.120,05,i Required Room Closet Space  i. Closet space in each sleeping room shall be twenty inches by twenty-two inches (20" x 22") per patient/resident. Common closets utilized by two (2) or more patients/residents shall be provided with substantial dividers for separation of each patient's/resident's clothing for prevention of cross contamination. All closets shall be equipped with doors. Freestanding closets shall be deducted	C 409	C 409 Please refer to attached waiver regarding closet space	

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C 409	Continued From page 2  from the square footage in the sleeping room. This Rule is not met as evidenced by: Based on staff interview and observation it was determined the facility did not provide the required closet space of 20 inches x 22 inches for residents in the TRU (Transitional Rehabilitation Unit) in the facility. Findings include:  On 4/29/14, at about 5:20 p.m., the Administrator confirmed that the closets had not changed in size and all of the closets in the residents' rooms on the TRU were smaller than the required size.	C 409	C 644 Please refer to F 441	
C 644	02.150,01,a,I Handwashing Techniques  a. Methods of maintaining sanitary conditions in the facility such as:  i. Handwashing techniques. This Rule is not met as evidenced by: Refer to F 441 as it related to hand hygiene.	C 644	C 645 Please refer to F 441  <b>C 664 –</b>  1.The facility will meet quarterly with the required members for the Infection Control Committee.	
C 645	02.150,01,a,ii CARE OF EQUIPMENT  ii. Care of equipment. This Rule is not met as evidenced by: Refer to F 441 as it related to infection control regarding bedpans, collection hats, and heating pads.	C 645	2. Committee agenda, notes and sign-in sheet record will be kept.  3. Committee met 5/08/14	<b>C 664</b>  Corrective action was completed 5/08/14
C 664	02.150,02,a Required Members of Committee  a. Include the facility medical director, administrator, pharmacist, dietary services supervisor, director of nursing services, housekeeping services representative, and	C 664	4. a)Administrator will monitor the attendance.  b) Monitoring will be conducted monthly for 3 months. Attendance monitoring of the meeting on a quarterly basis.	Quarterly meetings thereafter

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C 664	<p>Continued From page 3</p> <p>maintenance services representative. This Rule is not met as evidenced by: Based on staff interview and review of the Infection control Committee (ICC) meeting attendance records, it was determined the facility did not ensure the Medical Director, Administrator and the DON (Director of Nurses), attended or participated in quarterly ICC meetings. This failure created the potential for a negative effect for all residents, staff, and visitors in the facility when facility management staff were not involved in implementing safe infection control practices. Findings included:</p> <p>On 4/29/14 at 2:25 pm, the surveyor stated the required members of the ICC and asked LN#9 Infection Prevention Specialist, whether each required member attended the meetings. LN#9 stated, the Medical director, DON and the current Administrator do not attend the ICC meetings quarterly. The surveyor asked if the prior Administrator had attended, and she stated, "I don't believe they have attended. In all honesty I do not believe they have been invited."</p> <p>On 4/30/14, the sign in sheets for the ICC meeting, dated October 1, 2013 through April 29, 2014, were provided to surveyors. Attendance records for October 22, 2013, documented the DON attended the ICC meeting and that the Unit Spervisor attended the March 4, 2014 meeting, however the Medical Director and Administrator had not attended either meetings.</p> <p>On 4/30/14 at 1:30 pm, the Administrator was informed of the findings. No additional information was provided.</p>	C 664		

Bureau of Facility Standards

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C 679	Continued From page 4	C 679	C 679 Please refer to F248	
C 679	02.151,03,d Individualized Activity Plan  d. Develop and implement an individual activity plan for each patient/resident which reflects the interests and needs of the patient/resident. This Rule is not met as evidenced by: Refer to f248 pertaining to Activites of interest provided to residents.	C 679		
C 778	02.200,03,a PATIENT/RESIDENT CARE  03. Patient/Resident Care.  a. A patient/resident plan of care shall be developed in writing upon admission of the patient/resident, which shall be: This Rule is not met as evidenced by: Refer to F 279 as it related to initial care plans.	C 778	C 778 Please refer to F 279	
C 779	02.200,03,a,i Developed from Nursing Assessment  i. Developed from a nursing assessment of the patient's/resident's needs, strengths and weaknesses; This Rule is not met as evidenced by: Refer to F 272 as it related to safety assessments for the use of bed/side rails and torso belts.	C 779	C 779 Please refer to F 272	
C 782	02.200,03,a,iv Reviewed and Revised  iv. Reviewed and revised as needed to reflect the current needs of patients/residents and current goals to be accomplished; This Rule is not met as evidenced by:	C 782	C 782 Please refer to F 280	

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C 782	Continued From page 5  Refer to f 280 pertaining to resident's care plans being updated to reflect the care provided.	C 782		