



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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

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

**CERTIFIED MAIL: 7012 1010 0002 0836 1604**

June 9, 2014

Jed W. Gines, Interim Administrator  
BridgeView Estates  
1828 Bridgeview Boulevard  
Twin Falls, ID 83301-3051

Provider #: 135113

Dear Mr. Gines:

On **May 23, 2014**, a Recertification, Complaint Investigation and State Licensure survey was conducted at BridgeView Estates by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be one that comprises a pattern that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies and a similar State Form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 3). **Please provide ONLY ONE completion date for each federal and state tag in column (X5) Completion Date** to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.

After each deficiency has been answered and dated, the administrator should sign both the Form

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 **June 23, 2014**. Failure to submit an acceptable PoC by **June 23, 2014**, may result in the imposition of civil monetary penalties by **July 14, 2014**.

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

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

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

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

All references to federal regulatory requirements contained in this letter are found in *Title 42, Code of Federal Regulations*.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS), if your facility has failed to achieve substantial compliance by **June 27, 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 27, 2014**. A change in the seriousness of the deficiencies on **June 27, 2014**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **June 27, 2014** includes the following:

Denial of payment for new admissions effective **August 23, 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 **November 23, 2014**, if substantial compliance is not achieved by that time.

**Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.**

If you believe these deficiencies have been corrected, you may contact Lorene Kayser, L.S.W., Q.M.R.P. or David Scott, R.N., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **May 23, 2014** and continue until substantial

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compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the noncompliance at the time of the revisit, if appropriate.

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

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

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

- BFS Letters (06/30/11)

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

This request must be received by **June 23, 2014**. If your request for informal dispute resolution is received after **June 23, 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

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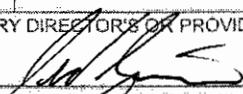
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135113</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>05/23/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>BRIDGEVIEW ESTATES</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1828 BRIDGEVIEW BOULEVARD TWIN FALLS, ID 83301</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 000	<p><b>INITIAL COMMENTS</b></p> <p>The following deficiencies were cited during your annual Federal recertification and complaint survey.</p> <p>The surveyors conducting the survey were: Amy Barkley, RN, BSN, Team Coordinator Sherri Case, LSW, QMRP Becky Thomas, RN Lauren Hoard, RN, BSN</p> <p>The survey team entered the facility on 5/19/14, and exited the facility on 5/23/14.</p> <p>Survey definitions: BIL = Bilateral LE = Lower Extremity LN = Licensed Nurse MAR = Medication Administration Record PRN = As needed SDTI = Suspected Deep Tissue Injury TAR = Treatment Administration Record</p>	F 000	<p><i>Preparation and/or execution of the plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies</i></p>	
F 225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) <b>INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</b></p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p>	F 225	<p><b>F 225</b></p> <p>Resident #14 will have all allegations of abuse thoroughly investigated by the facility and resident # 18 will have incidents of unknown injury thoroughly investigated by facility as per Bureau of Facility Standards Resident Abuse Reporting SNF/NF's Informational Letter 2014-5-1.</p>	<b>6/27/14</b>

RECEIVED  
JUN 23 2014  
FACILITY STANDARDS

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

TITLE

(X8) DATE



Executive Director

6/19/14

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

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F 225	<p>Continued From page 1</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview it was determined the facility failed to ensure all allegations of abuse were thoroughly investigated and incidents of injury from unknown source were investigated. This was true for 2 of 3 investigations reviewed and affected Residents #s 14 and 18. Failure to thoroughly investigate injuries of unknown origin and allegations of abuse placed residents at risk for abuse/neglect.</p> <p>1. The Bureau of Facility Standards Resident Abuse Reporting SNF/NF's Informational Letter 2014-5-1 includes guidance that residents</p>	F 225	<p>All residents have the potential to be affected. All residents will have allegations of abuse and incidents of injury from unknown source thoroughly investigated by facility as per Bureau of Facility Standards Resident Abuse Reporting SNF/NF's Informational Letter 2014-5-1. Audits are being completed to ensure compliance.</p> <p>Staff in-serviced on having all allegations of abuse and incidents of injury from unknown source thoroughly investigated as per Bureau of Facility Standards Resident Abuse Reporting SNF/NF's Informational Letter 2014-5-1.</p> <p>DON, ED or designee will audit any allegations of abuse or incidents of injury of unknown source as they occur for allegations of abuse and for incidents of injury from unknown source starting 6/23/14 to ensure that Bureau of Facility Standards Resident Abuse Reporting SNF/NF's Informational Letter 2014-5-1 is being followed. This will be done for eight weeks then monthly for 6 months to ensure compliance. Results of the audit will be reviewed with RVP and/or RDCS and taken to PI monthly meeting starting with the July meeting.</p>	

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F 225	<p>Continued From page 2</p> <p>involved will be interviewed and in cases of injury from unknown source, all staff having possible contact with the resident over the 24 hours prior to discovery of the injury must be interviewed.</p> <p>An anonymous letter, received by the facility on 1/6/14 alleged staff were taking residents out of the dining room before they were done eating and staff "makes a lot of very nasty, rude and degrading comments to residents and staff."</p> <p>The facility interviewed at least 13 staff regarding the allegations. One of the staff interviewed stated Resident #14 would be able to provide information regarding the allegations in the letter.</p> <p>On 5/22/14 at 4:13 p.m. the Administrator was asked if residents had been interviewed regarding the allegations. The Administrator stated the facility had interviewed residents, however, the interviews had not been documented. The surveyor stated Resident #14 was identified as being able to provide information regarding the allegations, however the investigation did not document the resident had been interviewed. Additionally the surveyor was informed (during the initial tour by LN #3 on 5/19/14 at approximately 12:15 p.m.) the resident was reliable to interview. The surveyor informed the Administrator the Bureau of Facility Standards Resident Abuse Reporting SNF/NFs Informational Letter required all interviews be documented.</p> <p>2. Resident #18 was admitted to the facility on 2/20/06 with diagnoses which included osteoarthritis, dementia without behavior disturbance and altered mental status.</p> <p>The resident's 3/17/14 quarterly MDS</p>	F 225			

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F 225	<p>Continued From page 3</p> <p>documented the resident was severely cognitively impaired and was totally dependent on staff for bed mobility, transfers, dressing and eating.</p> <p>During the initial tour on 5/19/14 at approximately 12:15 p.m. LN #3 informed the surveyor the resident was not interviewable, however, the resident was visited daily by a family member.</p> <p>Incident Follow-up &amp; Recommendation Forms for the resident documented the following:</p> <p>12/1/13 - at 7:00 a.m. when the CNA pulled back the covers there was "dried blood all over the top" of the resident's left hand. A family member denied seeing the injury on the day prior.</p> <p>The only staff statement attached to the investigation was by the CNA who reported the injury.</p> <p>12/15/13 - at 6:15 a.m. a CNA observed a skin tear to the resident's right arm. The resident's family member stated the the skin tear had not been there on the previous evening.</p> <p>NOTE: The investigation did not include any interviews with staff regarding the injury of unknown source.</p> <p>3/13/14 - The Preliminary information documented on 3/13/14 at 6:30 p.m. "found another bruise on her foot."</p> <p>The investigation did not include any interviews with staff or other information from the family member.</p> <p>4/30/14 - The Preliminary information</p>	F 225			

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F 225	<p>Continued From page 4</p> <p>documented on 4/25/14 at 1:20 a.m. "CNA found bruise measuring 7 cm x 5 cm" on the resident's left elbow.</p> <p>The investigation did not include any information from the resident's family member or staff who had worked with the resident in the previous 24 hours.</p> <p>Note: There was no documentation that CNA's who had worked with the resident the previous 24 hours were interviewed regarding any of the incidents of injury from unknown source as required by the informational letter. Additionally the only information for each incident documented from the family member (who visited her daily), was the injury had not been observed on the previous day.</p> <p>The resident's family member was interviewed on 5/22/14 at 1:45 p.m. During the interview with the surveyor he stated he had concerns with "rough handling" and he had received a call on 5/19/14 regarding an injury to the resident's left leg. The family member was upset and stated he had reported another bruise to the resident's left lower leg on 5/22/14.</p> <p>On 5/22/13 at 4:35 p.m. the Administrator stated there was no documentation staff had been interviewed regarding the injuries from unknown source. The Administrator stated staff were interviewed and if staff were not working during the investigation they would be called. The Administrator stated the phone calls were not documented.</p> <p>On 5/23/14 at 10:45 a.m. the Administrator and the DON were informed of the above concerns.</p>	F 225			

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F 225	Continued From page 5 The facility provided no further information regarding the issue.	F 225			
F 241 SS=D	<b>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</b>  The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.  This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview, and medical record review it was determined the facility failed to ensure a resident as free from embarrassment related to visible evidence of urinary incontinence. This was true for 1 of 15 (#6) sampled residents. This deficient practice had the potential to cause more than minimal psychosocial harm when a passerby could see a urine-soaked blanket placed under her wheelchair.  Resident #6 was admitted to the facility with multiple diagnoses to include muscle weakness, osteoarthritis, morbid obesity, and difficulty walking.  The resident's most recent Annual MDS dated 3/12/14 coded the following: - Cognitively intact. - Extensive assist of two people for bed mobility, dressing, and toilet use. - Total dependence of two people for transfers.  The resident's Continence Care Plan dated 6/20/12, documented the following, check and	F 241	<b>F 241</b>  Resident #6 is being toileted when asked to be free from embarrassment caused by incontinence.  All residents have the potential to be affected. Residents are being toileted when asked to be free from embarrassment caused by incontinence. Audits are being done to ensure compliance.  Staff in-serviced to toilet residents when they ask to be toileted, toilet residents per their care plan or if resident has visibly soiled clothes to change their clothes immediately.  Nurse managers to complete audits on 10% of residents three times per week times eight weeks, then once a week times eight weeks, then once every two weeks times eight weeks to ensure a resident is free from embarrassment related to visible evidence of urinary incontinence. Audits to start 6/23/14. Results of the audits will be reviewed with ED/DON and will be taken to the PI monthly meeting starting with the July meeting.	<b>6/27/14</b>	

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F 241	<p>Continued From page 6</p> <p>change and offer the bed pan every hour. The resident requires extensive assist of 1-2 for toileting/elimination tasks.</p> <p>On 5/20/14 the following was observed:</p> <ul style="list-style-type: none"> <li>- 2:00 PM, the resident was observed sitting in her wheel chair, at the end of her bed, facing the door. A visibly wet bath blanket was on the floor under the resident's wheelchair.</li> <li>- 2:15 PM, the resident was observed sitting in her wheelchair with the visibly wet bath blanket on the floor under the resident's wheelchair. The surveyor observed urine dripping off of the resident's wheelchair onto the blanket and bare floor under the resident. The resident's pants from her upper thighs to her waist band in the front was saturated with urine. The back of her pants from her buttocks to her waist band was saturated with urine and the bottom one third of the resident's shirt was wet from urine. The hoyer sling and the wheelchair cushion underneath the resident was saturated with urine.</li> <li>- 2:20 PM, the surveyor asked the resident why the bath blanket was on the floor under her w/c. The resident stated she told the CNA between 1:30 PM and 1:45 PM she needed to use the bed pan. The CNA informed the resident she needed to get another CNA to assist with transferring the resident from the resident's w/c to the bed. The resident stated the CNA left to find help and by 1:55 PM when no had returned the resident voided in her pants. The resident stated she saw the CNA, who was supposed to be finding another CNA to help toilet the resident across the hall assisting another resident. The resident pushed her call light for assistance. The same CNA returned to the resident's room and saw the wet area under the resident's w/c and put a bath blanket on top of the urine. The resident stated</li> </ul>	F 241			

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F 241	Continued From page 7 she understood it took two staff to toilet her but she should not have to wait 25-30 minutes, or longer. The resident told the surveyor this happens several times during the week and she ends up voiding in her pants before she is toileted. - 2:30 PM, CNA #4 and CNA #5 from the evening shift assisted the resident on the bed pan. - 3:00 PM, CNA #4 was interviewed related to the above observation. The CNA stated she was given in report by the day shift, Resident #6 was wet and needed to be changed. The CNA stated approximately 4 days a week during report at shift change she is told the resident is wet and needs to be changed. - 9:15 PM, CNA's #5 and #6 were interviewed related to the above observation. CNA #5 & #6 stated 4 days out of 7 they come on shift and in report are told that Resident #6 is wet and needs to be changed. CNA #5 stated he had reported this to the nurse and the unit manager several times and nothing had been done about it.  On 5/21/14 at 7:25 PM the DNS was informed related to the above concern. No additional information was provided by the facility.	F 241			
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS  A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.  This REQUIREMENT is not met as evidenced by:	F 312	<b>F 312</b>  Residents #5, #19 and #20 are having adequate assistance for meal consumption.  All residents have the potential to be affected. Residents are having adequate assistance for meal consumption. Audits are being completed to ensure compliance.	<b>6/27/14</b>	

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F 312	<p>Continued From page 8</p> <p>Based on observation and staff interview, it was determined the facility did not ensure residents received adequate assistance for meal consumption. This was true for 1 of 10 sampled residents (#5) and 2 random residents #19 and #20 observed during a meal observation. The deficient practice had the potential to cause more than minimal harm if residents experienced malnutrition and/or weight loss. Findings included:</p> <p>During an evening meal observation, on 5/21/14 at 6:20 p.m., 3 Residents requiring assistance to consume their meals (#s 5, 19, and 20) were observed to be seated at the restorative dining table. CNA #7 was observed to be the only staff at the restorative table.</p> <p>* 6:30 p.m. - Resident #5 was observed to drop her food on her lap. The CNA was observed at that time to ask Resident #5 and Resident #20 if they needed assistance. Resident #20 stated she did not need assistance. Resident #5 stated she was doing "okay."</p> <p>*6:35 p.m. - The CNA returned to Resident #5 and gave her a bite of mashed potatoes. A few seconds later the CNA again asked Resident #20 if she could assist her to eat. Resident #20 stated she did not wish to eat her meal. The CNA did not ask the resident if there was anything she would like to eat or encourage her to eat more.</p> <p>*6:40 p.m. - Resident #5 pushed her wheelchair away from the table and CNA #7 redirected the resident back to the table and gave her a bite of cake.</p> <p>*6:45 p.m. - Resident #19 had been at the dining table leaning to the left and was approximately 1 1/2 to 2 feet from the table. The resident had a facial grimace when he leaned forward to drink</p>	F 312	<p>Staff in-serviced on ensuring that residents are having adequate assistance for meal consumption and to have the maximum staff to resident ratio at the restorative dining. CNA #7 to be included in the in-service.</p> <p>Manager assigned to restorative dining will audit three times per week times eight weeks, then once a week times eight weeks, then once every two weeks times eight weeks to make sure there is adequate assistance for meal consumption in restorative dining starting 6/23/14. Results of audits will be reviewed with the ED/DON and taken to the monthly PI meeting starting with the July meeting.</p>		

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F 312	<p>Continued From page 9</p> <p>his juice. The resident's meal was in front of him at the beginning of the observation at 6:20 p.m., but he was not offered assistance to eat until 6:45 p.m. (The resident's 5/16/14 Admission MDS documented a CVA with left sided deficit and dysphasia. The assessment also documented the resident required 1 person physical assist with meals.)</p> <p>*6:50 p.m. - The surveyor requested the DON to come to the dining room. The DON was asked how much of their meals the residents had eaten. The DON stated he would look at the meal monitor flow sheet. The surveyor stated all of the residents had eaten 0-10%. The DON did not comment regarding the lack of meal consumption by the residents. The DON was asked if 1 CNA was adequate to assist the 3 residents at the restorative dining table. The DON stated there needed to be more than 1 CNA.</p> <p>*6:55 p.m. - The DON was observed to ask Resident #19 if he needed assistance or his meal "heated" up.</p> <p>The meal monitors were reviewed and documented all of the identified resident's had consumed 25% of their meal.</p> <p>Please refer to F514 regarding inaccurate documentation of meal consumption.</p> <p>On 5/23/14 at 10:45 a.m. the Administrator and DON were informed residents were not able to consume their meals as there was not enough staff to help them. CNA #7 was observed to not sit with the residents and assist or encourage them to eat their meal. Additionally the meal monitor flow sheets were inaccurate regarding the amount of food consumed for the identified residents. The facility provided no further</p>	F 312			

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F 312	Continued From page 10 information.	F 312			
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES  Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.  This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, it was determined the facility failed to ensure residents who entered the facility without pressure ulcers did not develop pressure ulcers. This was true for 2 of 4 sampled residents (#s 2 & 3) reviewed for pressure ulcers when both residents developed suspected deep tissue injuries (SDTIs) after admission to the facility. This failure created the potential that residents would develop additional pressure ulcers, causing pain and potential for infection. Findings included:  1. Resident #3 was admitted to the facility on 4/14/14 with multiple diagnoses which included fracture of the hip and dementia.  The admission MDS assessment for Resident #3, dated 4/21/14, documented: * Moderately impaired cognition with a BIMS of 9; * Extensive assistance needed with 2 or more	F 314 F 314	F 314 Resident #3 has been discharged from facility. Resident #2 is receiving necessary assessments and treatment to promote healing of skin ulcers and ensure that resident will not develop pressure sores unless residents' clinical condition demonstrates that they are unavoidable.  All residents have the potential to be affected. Residents who are at increased risk of skin breakdown following a hip surgery related to immobility caused by pain and the scooting motion of the dominant heel for positioning will have interventions placed to help prevent pressure areas. Residents who wear Sage boots will have them on properly to help distribute pressure correctly while in those boots. Audits are being done to ensure compliance.  Staff in-serviced on residents who have had a hip surgery and are at an increased risk of skin breakdown related to immobility caused by pain and the scooting motion of the dominant heel for positioning and to	6/27/14	

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F 314	<p>Continued From page 11</p> <p>people for bed mobility, transfers, dressing and toilet use;</p> <p>* Range of motion impairment to one side of the lower extremities; and,</p> <p>* At risk for pressure ulcer development with no pressure ulcers.</p> <p>Resident #3's Care Plan, dated 4/14/14, documented:</p> <p>* Problems - Wound type/location, SDTI on left heel and Surgical wound right hip; and At risk for impaired skin integrity related to decreased independence with ADL's, mobility and dysphagia related to recent hospitalization for right hip fracture surgery with toe touch weight bearing status...; and</p> <p>* Approaches - Complete weekly skin assessment; Educate resident/responsible party about skin condition and treatment; Wound care as ordered, observe effectiveness of/response to treatment as ordered; special protective devices used: Pressure reducing mattress, cushion to wheelchair; Turn and reposition every 2 hours or more frequently, requires extensive assist for repositioning; Sage boots on at all times; and Float heels when in bed.</p> <p>Note: It is unclear which date the aforementioned interventions were initiated. The initiation/revision date was not provided anywhere on the Care Plan when new interventions were added. In addition, the aforementioned SDTI was on the right heel, not the left.</p> <p>The following documentation was gathered from Resident #3's Physician Orders (MD orders), care plan (CP), Wound Management Summary (WMS), Progress Notes (PN) and Pressure Ulcer Status Record (PUSR):</p>	F 314	<p>place interventions when this is observed such as Sage boots, foot cradle, wound nurse notification, etc. Staff in-serviced on the proper way to apply a Sage boot and if a resident has Sage boots ordered for both feet then the Sage boots have to be on both feet per MD order.</p> <p>Nurse managers will complete audits of 10% of residents three times a week for eight weeks, then once a week for eight weeks, then once every two weeks for eight weeks starting 6/23/14 to ensure that if they are at risk from pressure sores due to a hip surgery that proper interventions are in place and that Sage boots are on correctly and per MD orders. Results of the audits will be reviewed with the ED/DON and taken to PI monthly meeting starting with the July meeting.</p>		

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F 314	Continued From page 12 * 4/14/14 - MD orders, Encourage to float heels while in bed. LN to check every shift; Span mattress to bed; Pressure reducing cushion to wheelchair; * 4/25/14 - PN, "CNA asked me to to [sic] look at resident's heel. Has a large black spot. talked to wound nurse and asked her to take a look at is [it]. Placed foot in a sage boot and made sure that heels are floated. Will continue to monitor;" * 4/25/14 - PUSR, date first observed to right heel. Unstageable due to SDTI, Measured 6 cm (centimeters) by 7 cm; * 4/28/14 - PN, "WOUND NOTE - I was alerted that resident had a dark area to her right heel. I assessed her heel and found and dark purple discoloration with redness around that measures 6L X 7W [6 cm in length by 7 cm in width]. Skin is intact at this time with no fluid under the skin. Will leave OTA at this time so she can continue to wear her TED hose. Sage boot to be worn at all times. Resident stated she 'rubs her heel on stuff' so this should help reduce friction and pressure to the heel. She denied being diabetic. Husband present and aware of area and interventions. Resident had a right hip surgery and most likely is not moving this leg much because of pain. Heels have been floated. She did not have shoes on, only non-skid socks on. Will notify [Physician's name];" * 4/28/14 - WMS, Type of wound - Pressure - unsure of her vascular status; Location of wound - Right heel - SDTI, 6 cm by 7 cm Dark purple and non-blanchable; Status of wound - new; Current Treatments - OTA (Open to air); Current Interventions - Span air mattress, pressure reducing cushion and sage boots; and Barriers to healing - Right hip surgery - not moving her leg as much; * 4/28/14 - MD orders, Sage boots to feet on at all	F 314			

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F 314	Continued From page 13 times; Monitor SDTI to right heel; * 5/9/14 - PN, "WOUND NOTE- Right heel continues with SDTI to posterior heel. Area has decreased in size and localized to an area that measures 5L X 3.5W. Tissue dark and dry with scant red discoloration around. She stated she has some pain. Area intact and OTA. Sage boot in place;" * 5/9/14 - PUSR, unstageable, measured 5 cm (length) by 3.5 cm, dark and dry, improvement; * 5/13/14 - PN, "WOUND NOTE- Right heel continues to have SDTI. Area has localized more and measures 3L x 3.5W dark and dry. She denies pain. No bogginess or drainage. Sage boot in place...;" * 5/13/14 - PUSR, unstageable, measured 3 cm (length) by 3.5 cm, dark and dry, improvement; * 5/13/14 - MD orders, Keep pressure off right heel; * 5/15/14 - MD orders, Allevyn, Kerlix to right heel. Change every 3-5 days and PRN; * 5/19/14 - PN, "WOUND NOTE- Dressing changed to right heel. Area started as a SDTI and continues to be dry and dark with fluid reabsorbed to this area. Area is slightly smaller and measures 2.5 X 3W. There is a small portion under the dark area that has clear fluid in it. No pain with palpitation and assessment. Family present and felt that area looked a lot better. Sage boot in place. Educated family on the process that this type of wound usually follows and to avoid pressure and friction. I told the family that the dry cap of skin acts as a biological bandage and that unless it becomes boggy or infected we will leave it intact. They said that [Physician's name] told them the same thing when he looked at it;" and, * 5/19/14 - PUSR, unstageable, measured 2.5 cm (length) by 3 cm, dark, dry, clear fluid blister	F 314		

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F 314	<p>Continued From page 14 below, improvement.</p> <p>On 5/21/14 at 11:40 a.m., LN #1 was interviewed about the SDTI to Resident #3's right heel. When asked which interventions were put into place prior to the development of the SDTI, the LN said for every new admit there are standard interventions put into place which included floating heels, turning/repositioning, pressure reducing mattress, pressure reducing cushion to wheelchair, perineal care and protective creams. The LN added the facility does an initial skin assessment on admit followed by weekly skin assessments. The LN was asked which interventions were put into place after the SDTI had developed. She said they initiated sage boots and because the skin was intact, the area was left OTA with no bandage. Later on the Allewyn dressing was added for increased protection of the right heel. The LN said there was an increased risk for skin breakdown anytime there was surgery and suspected the SDTI developed from the hip surgery, which was often seen. She added there was also an increased risk for skin breakdown following surgery related to pain of the affected limb and the scooting motion with the dominant heel for body positioning.</p> <p>Note: The facility was aware of the increased risk of skin breakdown following a hip surgery related to immobility caused by pain and the scooting motion of the dominant heel for positioning. However, no additional interventions were added to protect the right heel.</p> <p>On 5/22/14 at 2:55 p.m., the surveyor observed Resident #3's right heel with the assistance of LN #1. The LN removed the sage boot, Kerlix and Allewyn dressing and used a mirror to assist in</p>	F 314			

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F 314	<p>Continued From page 15</p> <p>viewing the heel. The SDTI covered the posterior aspect of the heel and was a raised, black, dry and hard area. The surrounding skin just below the SDTI was red. No open areas, blisters or signs and symptoms of infection were observed. A new Allevyn dressing was placed over the heel, wrapped with Kerlix and the sage boot was placed to the right foot.</p> <p>On 5/22/14 at 7:00 p.m., the Administrator and DON were informed of the SDTI issue. No further information or documentation was provided.</p> <p>2. Resident #2 was admitted on 4/5/14 to the facility with multiple diagnoses to include Sepsis, edema, aftercare following surgery of the skin and subcutaneous tissue, spinal stenosis, and muscle weakness.</p> <p>The resident's Admission MDS dated 4/12/14 coded the following:</p> <ul style="list-style-type: none"> <li>- Moderately impaired cognition.</li> <li>- Extensive assist of two people for bed mobility, transfers, dressing, and toileting.</li> <li>- Functional limitation (impairment) in range of motion to bilateral upper and lower extremities.</li> <li>- Risk of pressure ulcers.</li> <li>- One unhealed pressure ulcer - stage 1 or higher.</li> </ul> <p>The resident's Impaired Skin Integrity Care Plan (CP) documented the following:</p> <ul style="list-style-type: none"> <li>* 4/5/14 - Complete Braden Scale risk assessment quarterly and pm. Complete weekly</li> </ul>	F 314		

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F 314	<p>Continued From page 16</p> <p>skin assessment, educate resident/responsible party about skin condition and treatment. Inspect skin during bathing, especially over bony prominence. Wound care as ordered, observe effectiveness of response to treatment as ordered. Observe skin daily and report red broken areas to the nurse. Turn &amp; reposition every 2 hours or more frequently. Requires extensive assist for repositioning.</p> <p>The resident's Physician's Orders (PO), Nurses Progress Notes (PN), wound management summary (WMS), Pressure Ulcer Status Record (PUSR), MARs, and TARS documented the following:</p> <ul style="list-style-type: none"> <li>* 4/5/14, PO, - Encourage to float heels while in bed. LN to check every shift. Encourage/Assist resident to turn side to side while in bed. Pressure reducing mattress to bed and pressure reducing cushion to wheelchair.</li> <li>* 4/17/14, PN, - SDTI light purple discoloration to the right [heel] that measures 5x5. Area OTA [open to air] and boot placed to offload. All skin is intact and boots will protect. Resident not wearing shoes prior to areas being found, only non-skid socks."</li> <li>* 4/18/14, PO, - Sage boots to bilateral feet on at all times for SDTI. Skin checks every Wednesday, on day shift.</li> <li>* 4/18/14, PO, - Sage boots on at all times.</li> <li>* 4/18/14, PO, - Foot cradle at end of bed.</li> <li>* 4/18/14, TAR, - "No shoes at this time," was written as information only and there was no documentation this was being done.</li> <li>* Unknown date, TAR, - "Foot cradle to bed, while in bed," was written as information only and there was no documentation this was being done.</li> <li>* 4/18/14, PUSR, - New unstageable pressure ulcer identified to right heel. The area is purple and measures 5x5 cm with unknown depth.</li> </ul>	F 314			

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F 314	<p>Continued From page 17</p> <p>* 4/21/14, Late entry for 4/19/14, PN, - The wound nurse documented, "I inspected her heels Saturday [4/17/14] and right heel with no discoloration or pain. I will consider this heel resolved." Will continue with sage boots to BIL (bilateral) heels. "I was unaware, but the resident has been wearing black shoes. She has had significant swelling to her BIL LE (lower extremity) and feet which may have caused her shoes to be ill fitting and increased pressure to her heels that was not normally a problem. Shoes to be left off."</p> <p>On 5/20/14 the following observations were made:</p> <p>*11:40 AM the resident was observed sitting in her wheelchair, she had non-skid socks on both feet and a boot on her left foot. There was no boot on her right foot and no padding between the resident's heel and the wheelchair pedal.</p> <p>* 12:45 - 1:30 PM, the resident was observed sitting in her wheelchair in the dining room eating lunch. The resident did not have a boot on her right foot which was still positioned directly on the foot pedal and the boot on the resident's left foot was not positioned correctly on her foot. The resident's left heel was resting in in the middle of the boot with the ball of her foot and her toes hanging approximately 2 inches out/off the front of the boot.</p> <p>* 1:30 PM, The resident was transported back to her room by CNA #7. The surveyor asked CNA #7 if the boot on the resident's left foot was positioned correctly. The CNA stated the boot was not on correctly. The CNA removed the boot on the resident's left foot and repositioned it so the foot was positioned correctly in the boot.</p> <p>* 1:45 PM, The surveyor asked CNA #7 if the resident was supposed to have a boot on her right foot. The CNA stated, "I believe so, but I am</p>	F 314		
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NAME OF PROVIDER OR SUPPLIER  <b>BRIDGEVIEW ESTATES</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1828 BRIDGEVIEW BOULEVARD TWIN FALLS, ID 83301</b>		
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F 314	Continued From page 18 not sure where it is." The CNA then left the resident's room with the resident's right heel resting directly on the foot pedal.  On 5/22/14 at 6:15 PM, the wound nurse was interviewed related to the development of the SDTI. The wound nurse stated interventions were put into place prior to the development of the SDTI on the resident's right heel. She stated all new admits have standard interventions in place to prevent pressure ulcer development. These interventions included floating heels, turning/repositioning, pressure reducing mattress, and pressure reducing cushion to wheelchair. The wound nurse was asked why the, "no shoes at this time and foot cradle while in bed" were written as information only and if the shoes were a contributing factor to the development of the SDTI to the resident's right heel. The wound nurse stated ill fitting shoes due to increased swelling in the resident's lower legs could have caused increased pressure on her heel. The wound nurse stated she is unsure why the SDTI developed. The wound nurse was asked if it the resident was supposed to have bilateral boots on at all times. She stated, "Yes." The surveyor informed the wound nurse related the above observation. She stated she did not know why the resident did not have the boot on. No further information was provided to resolve this concern.	F 314			
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323	F 323	6/27/14	

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F 323	<p>Continued From page 19</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure a resident was safe during cares and that a resident was safe with the use of side rails. This was true for 2 of 10 sampled residents (#s1 &amp; 2) when Resident #1 rolled out of bed during cares, and when Resident #2 was not assessed as safe with the use of side rails. These failed practices placed the residents at risk for serious injury. Findings included:</p> <p>1. Resident #1 was admitted to the facility on 11/9/10 and readmitted on 4/1/13 with multiple diagnoses which included infantile cerebral palsy, cerebrovascular disease and persistent vegetative state.</p> <p>The most recent quarterly MDS assessment for Resident #1, dated 3/11/14, documented: * Unable to complete interview for BIMS; * Total assist required with 2 or more people for bed mobility, transfers, dressing, bathing and toilet use; * Range of motion impairment to bilateral upper and lower extremities; and, * Always incontinent of bladder and bowel.</p> <p>Resident #1's Care Plan, dated 4/1/13,</p>	F 323	<p>Resident #1 has been discharged from facility. Resident #2 has had her half side rails d/c'd due to nonuse.</p> <p>Residents who rely on staff for ADL's or have side rails have the potential to be affected. Residents will not be turned away from a staff member providing cares in bed unless another staff member is on the other side of the bed and residents with side rails are being assessed for safety on the Initial and Quarterly Restraint Assessment form for by checking the box that says they have been assessed for safety and the assessment summary for the use of the side rails will have supporting documentation in it. Audits are being done to ensure compliance.</p> <p>Staff in-serviced that when providing cares by yourself to never turn a resident away from you to prevent them from rolling out of bed and if a resident has side rails, the box on the Initial and Quarterly Restraint Assessment form for the device being assessed for safety must be checked and supporting documentation placed in the assessment summary section.</p> <p>Nurse Managers will audit 10% of residents starting 6/23/14 during cares</p>	

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F 323	<p>Continued From page 20 documented:</p> <p>* Problems - Resident has ADL self-care deficit as evidenced by: needs total assist of 1-2 people with all ADLs, persistent vegetative state, CP (cerebral palsy), and CVA (cerebrovascular accident) with hemiparesis...; and,</p> <p>* Approaches - Requires total assist of two with bed mobility, transfers with Hoyer lift and toileting. Total assist of one with the other ADLs.</p> <p>An Incident Follow-Up and Recommendation Form for Resident #1, dated 2/6/14, documented:</p> <p>* Summary of Investigative Facts: "CNA was providing incont[inence] care for resident. CNA was standing on the left side of the bed, rolling the resident to the right side of the bed while changing her, CNA stated that the resident started rolling further to the right and rolled out of bed onto the floor face down on the landing strip, her arms contracted at her sides and legs crossed at her shins;" and,</p> <p>* Recommendations/Actions Taken: "Landing strip to both sides of bed, staff to roll resident toward them during cares and gain assistance from other staff as necessary, verbal education with staff."</p> <p>A Progress Note for Resident #1, dated 2/6/14, documented, "At 2200 [10:00 PM] this nurse was called to resident room. Staff stating that resident was on the floor. I went into the room and found resident had fallen from the right side of her bed, face down on the landing strip. Resident was making light crying noises. Her arms, normally contracted were at her sides. Her legs were straight out and the right leg was crossed over the left leg at the shin. Range of motion assessed, and resident made no additional s/s [signs and symptoms] pain or discomfort with</p>	F 323	<p>being provided by nursing staff to ensure they are turning residents towards the caregiver, audits to be completed three times a week for eight weeks, then once a week for eight weeks, then every two weeks for eight weeks. DON or designee will audit starting 6/23/14 Initial and Quarterly Restraint Assessment forms to ensure the box has been checked that deems the side rail is safe and the assessment summary section has supporting documentation in it for all residents with side rails. These audits will be done weekly for eight weeks, then every two weeks for eight weeks then every month for two months. Results of the audits will be reviewed with the ED/DON and taken to P1 monthly meeting starting with the July meeting.</p>		

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F 323	<p>Continued From page 21</p> <p>motion of any extremities [sic]. Resident rolled to back on a hoier sling, and then lifted to bed surface, using 6 person assistance. Resident further assessed. Crying noises had stopped. Resident has redness to right shin, as well as center of forehead. Resident is unaware of her surroundings and non-verbal at baseline. Vitals assessed within normal limits. Neuro checks are difficult because of residents uncontrolled intraocular movements, pupil dilation. Resident also has contractures of bilateral upper extremities [sic], as well as bilateral foot drop. Resident does not have intact motor function at baseline. [Physician's name] called on call for [Physician's name] at 2230 [10:30 p.m.]. He had no new orders. Residents brother...called at 2215 [10:15 p.m.]. He was upset, however he directed just to continue to monitor for latent injuries. Staff member performing incontinence care for the resident at the time of incident. She stated that she had rolled the resident away from her, and the resident began sliding further away from her and out of her control and onto the floor on the opposite side of the bed. Staff was alone with the resident at the time. Neurochecks will continue per policy. Staff will continue to monitor resident for latent injuries."</p> <p>An Acute Care Plan for Resident #1, dated 2/6/14, documented: * Problem - Fall from bed; * Approaches - Get assistance when changing/providing incontinence cares; Roll resident toward CNA to provide stability; and Monitor for latent injuries.</p> <p>Resident #1's Care Plan documented: * Problems - Resident is at increased risk for fall related injury; fall risk factors present as</p>	F 323		

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F 323	<p>Continued From page 22</p> <p>determined by Fall Risk Screen, fall risk scores relating to: immobility related to persistent vegetative state, functional problem: total dependence for positioning and transfers...; * Approaches - Fall risk assessment quarterly and PRN; provide environmental adaptations...; When rolling resident, ensure that resident is being rolled toward the staff member to reduce the risk of rolling off the bed, added 3/25/14 [Note: 47 days after the incident the intervention was added to the care plan for fall prevention.].</p> <p>On 5/22/14 at 9:30 a.m., LN #2 was interviewed about Resident #1's fall on 2/6/14. The LN said the resident requires 1-2 people for cares and it depended on which staff was working whether or not 1 or 2 people were needed. She said the CNA working with the resident at the time of the fall was a staff member who could perform cares without the assistance of a second person. When asked how many people are required to assist the resident during cares after the fall, the LN said it still depended on who was working with the resident.</p> <p>On 5/22/14 at 7:00 p.m., the Administrator and DON were informed of the fall issues. No further information or documentation was provided.</p> <p>2. Resident #2 was admitted to the facility with multiple diagnoses to include sepsis, edema, aftercare following surgery of the skin and subcutaneous tissue, spinal stenosis, and muscle weakness.</p> <p>The resident's Admission MDS, dated 5/1/14, coded the following: - Moderately impaired cognition. - Extensive assist of two people for bed mobility, transfers, dressing, and toileting.</p>	F 323		

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F 323	<p>Continued From page 23</p> <ul style="list-style-type: none"> <li>- Functional limitation (impairment) in range of motion (ROM) to bilateral upper and lower extremities.</li> <li>- Restraints in bed, bilateral side rails.</li> </ul> <p>NOTE: The resident's Admission MDS coded bed rail under P0100, Physical Restraints, and did trigger a Care Area Assessment for restraints. However, the only area on the resident's care plan which identified the use of the side rails was the Fall Care Plan. The Fall Care Plan documented the resident was to use 1/2 Side rail(s), on her bed, as an enabler.</p> <p>Resident #2's bed was observed to have side rails in the upraised position on 5/20/14, at 2:00 PM, 4:00 PM and 5:00 PM and on 5/21/14, at 10:30 AM, 1:45 PM, and 4:30 PM.</p> <p>An Initial and Quarterly Restraint Assessment form, dated 4/5/14, documented:</p> <ul style="list-style-type: none"> <li>- No falls in the past 120 days.</li> <li>- Short/Long term memory intact.</li> <li>- Impaired muscle strength or decreased ROM to hips/knees.</li> <li>- Normal sitting balance.</li> </ul> <p>There was a box on the form for the assessor to check after the side rails had been determined safe for use. The box was blank. Additionally, the assessment summary for the use of the siderails was blank.</p> <p>On 5/20/14, at 9:25 AM, Resident #2 was interviewed related to the use of the siderails. The resident stated she did not need or use the side rails in bed to move around. The resident stated the only time she used the side rails was to get out of bed.</p>	F 323			

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F 323	Continued From page 24 On 5/22/14, at 5:45 PM, RN #3 was interviewed related to the above findings. RN #3 stated she was not sure if a safety assessment had been completed or not prior to applying the siderails. RN #3 stated she would have to look at the resident's medical record. No further information was provided to resolve this concern.	F 323			
F 329 SS=E	On 5/22/14, at 7:00 PM, the Administrator and DNS were informed related to the above concern. No additional information was provided by the facility to resolve this concern. <b>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</b>  Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.  Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329	<b>F 329</b>  Resident #5 had diagnosis of Remeron properly changed on 6/13/14 to depression from insomnia therefore not needing an insomnia care plan. Resident #5 has a care plan with signs and symptoms of how the depression is displayed for this resident. Resident #5 has a diagnosis on the Behavior/Intervention Monthly Flow Record (BIMF). Resident #5 had a GDR done on Remeron 6/13/14. Resident #9 care plan for Mood and Behavior now includes the symptoms of depression this resident displays. Resident #9 care plan for Potential for Anxiety now identifies how residents' anxiety is displayed and the triggers for residents' anxiety as well as non-pharmacological interventions to try to	<b>6/27/14</b>	

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F 329	Continued From page 25  This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility failed to: *Ensure medication regimens were evaluated for the need for duplicate therapies; *Ensure appropriate indications and monitoring for the use of psychotropic medications. *Ensure medication regimens were evaluated for possible for possible dose reduction. *Identify non-pharmacological interventions prior to initiating or increasing medications. This was true for 4 of 11 residents (Resident #s 5, 9, 10, and 11) sampled for the use of psychotropic medications. These failures created the potential for harm should the medication regimen result in an unanticipated decline or newly emerging or worsening symptoms.. Findings included:  1. Resident #5 was admitted to the facility on 9/2/05 and readmitted on 3/10/14 with multiple diagnoses which included psychosis and depressive disorder.  The resident's 5/1/14 recapitulation Physician's Orders included an order for Mirtazapine (antidepressant) 15 mg at bedtime for insomnia with a start date of 3/10/14.  The resident did not have a care plan for insomnia. The resident did have a care plan for depression, however, it did not include signs or symptoms of how the depression was displayed such as insomnia, tearfulness etc.	F 329	relieve anxiety. Resident #9 BIMF now has clarified how residents' anxiety is displayed. Resident #9 has a GDR request sent to MD 6/18/14 for Lexapro and Ativan. Resident #10 care plan now includes how resident depression is displayed and non-pharmacological interventions when resident is displaying depression. Resident #10 now has a care plan for insomnia. Resident #10, MD has been consulted to do a GDR on Wellbutrin 6/12/14. Resident #10, MD has been sent a request for risks and benefits of using two antidepressants. Resident #11 has been discharged from facility.  All residents on antidepressant(s), anti-anxiety and antipsychotics have the potential to be affected. Audits are being completed to ensure compliance.  Nursing staff and Social Service Designee's in-serviced that medication regimens are being evaluated for the need for duplicate therapies, ensure appropriate indications and monitoring(BIMF) for the use of psychotropic medications, ensure medication regimens are being evaluated for possible dose reduction and identify non-pharmacological interventions prior to initiating or		

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F 329	<p>Continued From page 26</p> <p>The resident's Behavior/Intervention Monthly Flow Records (BIMF) for 3/14 did not document a diagnosis but documented there were 0 signs of depression and the resident slept 6-8 hours every night on the night shift. The BIMF for 4/14 documented a diagnosis of depression, 0 incidents of a "lowered mood" and 0 incidents of negative behaviors. The 5/14 BIMF documented a diagnosis of insomnia, no signs of depression and 0 hours of sleep for all 3 shifts.</p> <p>Note: The 4/14 form did not document how many hours the resident slept and the 5/14 form documented 0 hours of sleep for the entire month.</p> <p>On 5/22/14 at approximately 10:30 a.m. LN#2 was asked if the resident received the antidepressant for depression or insomnia and if the resident had been on the antidepressant at the facility prior to her readmission on 3/10/14. When asked if 6 hours of sleep was acceptable for this resident LN#2 stated yes. When asked if a reduction in the medication had been discussed she stated she would get the information.</p> <p>Later that day the Social Services Designee (SSD) provided documentation the resident had taken the antidepressant since 11/6/02 but did not provide a care plan to address the resident's insomnia. The SSD provided a Consultation Report dated 6/14/13 which documented the antidepressant be "increased back to 15 mg" due to a failed gradual reduction, however the facility did not provide documentation a reduction had been discussed recently, even though data documented for the past 3 months the resident had 0 incidents of behaviors and LN #2 stated the resident had adequate sleep.</p>	F 329	<p>increasing medications and will have specific approaches on care plan for psychotropic's.</p> <p>DON and SDC will complete audits of 10% of residents on psychotropic medications three times a week for eight weeks, then once a week for eight weeks, then once every two weeks for eight weeks starting 6/23/14 to ensure medication regimens are being evaluated for the need for duplicate therapies, ensure appropriate indications and monitoring(BIMF) for the use of psychotropic medications, ensure medication regimens are being evaluated for possible dose reduction and identify non-pharmacological interventions prior to initiating or increasing medications and will have specific approaches on care plan for psychotropic's. Results of the audits will be reviewed with the ED/DON and taken to PI monthly meeting starting with the July meeting.</p>		

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F 329	<p>Continued From page 27</p> <p>2. Resident #9 was admitted to the facility on 11/30/11 with diagnoses which included hypothyroidism, osteoarthritis and anemia.</p> <p>The resident's 5/14 recapitulation Physician's Orders included an order for Lexapro (antidepressant) 5 mg everyday with a start date of 12/18/13. There was also an order for Lorazepam (anxiolytic) 1 mg every evening with a start date of 4/1/14.</p> <p>The resident's 11/30/11 Care Plan (CP) for Mood State included in the "Approaches" section to encourage family visits and for the resident to verbalize feelings/concerns. Staff were to observe for signs and symptoms of depression, administer medication and monitor for side effects of the medication. The CP did not include how the symptoms of depression were displayed such as tearfulness, isolation, refusal of cares etc.</p> <p>The resident's BIMF for 3/14 through 5/20/14 documented 0 signs/symptoms of depression.</p> <p>The resident's 5/21/12 CP for "Potential for Anxiety" documented in the Approach section to administer the medication per "MD (medical doctor) order." The CP contained no further approaches or nonpharmalogical interventions. Additionally the CP did not identify how the anxiety was displayed or what would trigger the anxiety.</p> <p>The BIMFs for 3/14 through 5/20/14 documented 0 signs/symptoms of anxiety. The BIMF did not clarify how the anxiety was displayed such as verbalizing fearfulness, refusal of cares, etc.</p>	F 329			

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F 329	<p>Continued From page 28</p> <p>On 5/22/14 at 10:35 a.m. the LN#2 stated the facility was aware of the above concerns and was in the process of revising the CPs. LN#2 was asked if a dose reduction had been discussed for either of the medications since there had been 0 signs or symptoms for almost 3 months. She stated she would check with the social service designee. Later that day the SS designee provided a note to the surveyor which stated the resident's medications would be reviewed for reduction the following week.</p> <p>3. Resident #10 was admitted to the facility on 11/27/08 and readmitted on 5/27/12 with diagnoses which included dementia without behaviors, depressive disorder and restless leg syndrome.</p> <p>The resident's 5/14 recapitulation Physician's Orders included an order for Wellbutrin SR (antidepressant) 100 mg 2 times daily for depression and Trazadone (antidepressant) 50 mg at bedtime for insomnia. Additionally the Physician's Orders included an order to document hours of sleep every shift.</p> <p>The resident's 6/6/12 "Mood" Care Plan documented a diagnosis of depression and was at risk for "worsening depression." The Approach section included visits by social services, observe for decline in mood, and to review medication quarterly or as needed and to administer medication. The CP did not include how the depression was displayed such as isolation, insomnia etc., or nonpharmalogical interventions by staff such as redirect by talking about things important to resident, involving in an activity etc.</p> <p>The resident's BIMFs for 3/14 through 5/19/14</p>	F 329			

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F 329	<p>Continued From page 29 documented 0 incidents of depression.</p> <p>On 5/22/14 at 10:20 a.m. LN #2 stated the facility was now aware of the need specific symptoms needed to be in the CPs and was in the process of revising them. LN #2 was asked if the facility had looked at the risk and benefits for the use of 2 antidepressants, if the physician had provided justification for the need for 2 antidepressants or if there was a CP for insomnia. LN #2 was also asked if Wellbutrin had been reviewed for a reduction since there had been 0 incidents of depression documented for 3 months of depression. LN #2 stated she would check into the concerns. Later on 5/22/14 the Social Service designee provided a note which stated the medications would be reviewed for reduction the following week, however, no other information was provided.</p> <p>On 5/23/14 at 10:45 a.m. the Administrator and the DON were informed of the above concerns. The facility provided no further information.</p> <p>4. Resident #11 was admitted to the facility on 4/4/14 and readmitted on 5/12/14 with multiple diagnoses which included bipolar disorder and depression.</p> <p>The most recent admission MDS assessment for Resident #11, dated 4/22/14, documented: * Intact cognition with a BIMS of 15; * Depression severity score of 0 and no behaviors exhibited; and, * Did not receive antipsychotic or antidepressant medication 7 out of the last 7 days.</p> <p>May 2014 Physician's Orders (recapitulation orders) for Resident #11 documented: * Abilify 5 mg (milligrams), take one tablet by</p>	F 329			

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F 329	<p>Continued From page 30</p> <p>mouth every day. Diagnosis bipolar; * Cymbalta 60 mg capsule, take one capsule by mouth twice daily. Diagnosis bipolar; * Lyrica 300 mg, take one capsule by mouth twice daily. Diagnosis bipolar; and, * Zoloff 100 mg, take one tablet by mouth every day. Diagnosis bipolar. The aforementioned medications had a start date of 4/4/14.</p> <p>Resident #11's Interim Care Plan, dated 5/12/14, had a column to create a plan of care for Mood and Behavior. The section had a line through it. In addition, there was not a Care Plan for the use of antipsychotics or antidepressants.</p> <p>An April 2014 Behavior Care Plan for Resident #11 documented all zeros for the behavior of, "S/S [signs and symptoms] depression." The resident's medical record did not contain behavior monitoring for the month of May 2014.</p> <p>On 5/21/14 at 4:18 p.m., LN #3 said she did not know why Resident #11 received four medications for the diagnosis of bipolar, the resident was just on them. The LN was asked what the resident's care plan said about bipolar or mood. After reviewing the care plan the LN saw the line drawn through the Mood and Behavior section and stated, "That's not good, [it's] marked off." When asked what the signs and symptoms of depression were for Resident #11, the LN said crying, change of behavior and tearfulness. LN #3 said the CNA's reported mood and behavior or signs and symptoms of depression to the nurses and the nurses would document on the behavior monitors.</p> <p>Note: The resident's medical record did not</p>	F 329			

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F 329	Continued From page 31 contain justification for the use of multiple antipsychotics and antidepressants for the diagnosis of depression. There was not a care plan for mood and behavior, or for the use of antipsychotics and antidepressants. In addition, target behaviors were not identified on the behavior monitoring and behaviors were not monitored for the month of May 2014.	F 329			
F 371 SS=E	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 did not ensure food was prepared in a sanitary environment. This had the potential to effect 14 out of 14 sampled residents (#s 1-14) and all residents who ate meals in the facility. This created the potential for cross-contamination of food and exposed residents to potential sources of pathogens. Findings included:  On 5/19/14 at 11:25 AM, during the initial tour of the kitchen with the Director of Dining Services in attendance, the following concerns were identified:	F 371	<b>F 371</b> Residents #1-14 are having their food procured, stored, prepared in a sanitary environment. Grill ovens underneath with a wet greasy floor was cleaned, greasy screens were cleaned, grease filled sponges were thrown away, razorblade/grill scraper and oven brick were stored properly. The box of trash in the cheese cooler was removed. Old plastic pitted/scratched bowls have been replaced. Hair nets have been stored at all entrances to the kitchen.  All residents have the potential to be affected. Residents food is being procured, stored and prepared in a sanitary environment. Audits are being completed to ensure compliance.  Dietary in-serviced to ensure that food is procured, stored and prepared in a sanitary environment such as cleaning	<b>6/27/14</b>	

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F 371	Continued From page 32 *The grill with ovens underneath contained an open section with a wet greasy floor which had several greasy screens, grease filled sponges, razor blade/grill scraper and oven brick which were used for cleaning the grill. *The cheese cooler contained a box of trash filled with a pan, 2 butters, 5 margarines, 1 creamer and scraps of tortilla shells. *Plastic serving bowls were observed and 11 out of 16 bowls were pitted and scratched.  The Director of Dining Services (DDS) stated the floor and grill cleaning supplies were not normally kept in this condition and he would have it cleaned properly. He stated the razor blade/grill scraper was normally kept in a bucket. When the cheese cooler was opened, the DDS was surprised to see the box of trash on the bottom of the cooler and stated, "that shouldn't be in there, someone must have stuck it there." When observing the plastic serving bowls, the DDS stated, "These are usually checked every day but they aren't checking them good enough."  The 2009 FDA Food Code, Chapter 4, Part 4-6, Cleaning of Equipment and Utensils, Subpart 601.11 Equipment, Food-Contact Surfaces, Nonfood Contact Surfaces, and Utensils indicated, "(A) Equipment food-contact surfaces and utensils shall be clean to sight and touch. (B) The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) Non food-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris."  The 2009 FDA Food Code chapter 4 Equipment,	F 371	underneath grill ovens, wet greasy floors, greasy screens, grease filled sponges should be thrown away, razorblade/grill scraper and oven brick must be stored properly and no boxes of trash in the cheese cooler and old plastic pitted/scratched bowls must be replaced and hair nets available at entrance of kitchen and to be worn at all times. The Dietary Manager attended in-service on wearing a hair net.  The Director of Dietary Services or their designee will monitor sanitary practices daily starting 6/23/14 the DDS will do audits weekly for 8 weeks, then every two weeks for 8 weeks, then monthly for two months. The Consultant Registered Dietician will perform a monthly, unannounced sanitation audit starting 6/23/14 to assure compliance to sanitation standards for a minimum of 6 months. Results of the audit will be reviewed with the ED and taken to PI monthly meeting starting with July meeting		

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F 371	<p>Continued From page 33</p> <p>Utensils, and Linens, Subpart 4-202 Cleanability documented, "4-202.11 Food-Contact Surfaces. (A) Multiuse food-contact surfaces shall be: (1) Smooth; (2) Free of breaks, open seams, cracks, chips, inclusions, pits, and similar imperfections..."</p> <p>On 5/20/14 at 10:40 AM, the Dietary Manager was observed by the surveyor in the kitchen without a hair net. When asked about not wearing a hair net, the DM stated he knew he should have a hair net on whenever he was in the kitchen, however, he had just arrived at the facility and was trying to locate the DDS.</p> <p>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 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>On 5/21/14 at 7:30 PM, the Administrator and DON were made aware of the kitchen concerns. No further information was received from the facility.</p>	F 371			

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F 514 SS=E	<p><b>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE</b></p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to maintain clinical records on each resident in accordance with accepted professional standards and practices to ensure resident care plans were complete and accurate. This was true for 5 of 14 (#s 1 through 5, #7 and #18) sampled residents and 2 Random Resident #s 19 &amp; 20). This deficient practice created the potential for the residents' care to be based on incomplete or inaccurate information and increased the risk for complications due to inappropriate care or interventions. Findings included:</p> <p>1. During an evening meal observation, on 5/21/14 at 6:20 p.m., Residents #s 2, 5, 19, and 20 were observed to be seated at the restorative dining table. Each of the residents consumed less than 10% of their meal.</p>	F 514	<p><b>F 514</b></p> <p>Resident # 1-5, 7, 9, 10, 18, 19, and 20 will have their clinical records maintained in accordance with acceptable professional standards and practices.</p> <p>All residents have the potential to be affected and will have their clinical records maintained in accordance with acceptable professional standards and practices. Audits are being completed to ensure compliance.</p> <p>Nursing has been in-serviced how to correctly document meal intakes, in-serviced that residents who are care planned for every 2 hour toileting must be documented in RITA for 2 hour toileting. Medical records in-serviced when residents are seen by their physician MR must ensure the progress notes are received and placed in the medical record. Nursing and members of the IDT that add approaches to care plans have been in-serviced on dating and initialing the approach added, if discontinuing an approach date of discontinuation must be added. When care plans are periodically reviewed MDS has been in-serviced to ensure all</p>	<b>6/27/14</b>	

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F 514	<p>Continued From page 35</p> <p>After the observation, the surveyor showed the DON the residents had consumed 0% to 10% of the meal. The DON did not comment regarding the lack of meal consumption by the residents.</p> <p>The meal monitors were reviewed and documented all of the identified resident's had consumed 25% of their meal.</p> <p>On 5/23/14 at 10:45 a.m. the Administrator and DON were informed the meal monitor forms were inaccurate regarding the amount of food consumed for the identified residents. The facility provided no further information.</p> <p>2. Review of residents #s 4, 5, 7, 9, and 10's Care Plans revealed the Care Plans did not include in the Approach section the dates interventions were implemented. The onset date for the "Problem" section was documented on the Care Plans, but if interventions were added after the onset date the Care Plan did not reflect the date the intervention was implemented.</p> <p>On 5/22/14 at 4:13 p.m. the Administrator was asked about the above concern. The Administrator stated if an implementation was added the interventions were hand written on the Care Plan and the computer program for the Care Plans did not have a way to document the date each intervention was implemented.</p> <p>3. Resident #7 was admitted to the facility on 3/27/14 with multiple diagnoses which included history of fall, aftercare for healing traumatic fracture of other bone (pelvic), atrial fibrillation, and renal insufficiency.</p>	F 514	<p>current approaches are added onto the new care plan.</p> <p>Nurse managers to complete audits on 10% of residents three times per week times eight weeks, then once a week times eight weeks, then once every two weeks times eight weeks to ensure residents in restorative dining meal intakes are correct and documentation of residents for toileting every two hours is correct. ED to complete audits on 10% of residents three times per week times eight weeks, then once a week times eight weeks, then once every two weeks times eight weeks to ensure resident physician visit notes are in the medical record. DON and SDC to complete audits on 10% of residents three times per week times eight weeks, then once a week times eight weeks, then once every two weeks times eight weeks to ensure new care plan approaches have date. Audits to start 6/23/14. Going forward from 6/23/14 approaches will be dated on the care plan. Results of the audits will be reviewed with ED/DON and will be taken to the PI monthly meeting starting with the July meeting.</p>		

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F 514	<p>Continued From page 36</p> <p>Resident #7's medical record contained an Acute Care Plan for the problem of falls, dated 5/14/14, with an intervention to "Toilet q [every] 2 hours and PRN to assist with continence" with a start date of 5/15/14. The Bladder Monthly Flow Report did not contain documentation the resident had been toileted every 2 hours and PRN.</p> <p>On 5/21/14 at 5:35 PM, Unit Manager #3 was interviewed by the surveyor and stated Resident #7 wanted to get up and use the bathroom by herself. She was placed on a toileting program as an intervention after the resident fell while attempting to go to the bathroom. When shown the Bladder Monthly Flow Report, Unit Manager #3 stated, "It's not charted, I'll need to do some education."</p> <p>On 5/22/14 at 7:00 PM, the DON was made aware of the concerns with the toileting program documentation. No further information was provided by the facility.</p> <p>4. Resident #3 was admitted to the facility on 4/14/14. The resident's medical record did not include the resident had been seen by the physician within 30 days of admission as required.</p> <p>On 5/21/14 at approximately 12:00 p.m. LN #3 stated she would check on the above concern. Later that day the facility stated the physician had been contacted and provided a faxed copy of the physician visit.</p> <p>5. Resident #1 was admitted to the facility on 11/9/10 and readmitted on 4/11/13. The resident's medical record did not include the resident had</p>	F 514			

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F 514	Continued From page 37 been seen by a physician within the past 60 days as required.  On 5/21/14 at approximately 12:00 p.m. LN#3 reviewed the medical record and stated she would contact the physician for a copy of the most recent physician visit. Later that day the facility provided a faxed copy from the physician which documented the resident had been seen by the physician within the past 60 days.	F 514			

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001080</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/23/2014</b>
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NAME OF PROVIDER OR SUPPLIER  <b>BRIDGEVIEW ESTATES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1828 BRIDGEVIEW BOULEVARD TWIN FALLS, ID 83301</b>
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C 000	<p><b>16.03.02 INITIAL COMMENTS</b></p> <p>The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2.</p> <p>The following deficiencies were cited during the annual licensure survey of your facility.</p> <p>The surveyors conducting the survey were: Amy Jensen, RN, BSN, Team Coordinator Sherri Case, LSW, QMRP Becky Thomas, RN Lauren Hoard, RN, BSN</p> <p>The survey team entered the facility on 5/19/14, and exited the facility on 5/23/14.</p>	C 000	<p><i>Preparation and/or execution of the plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies</i></p> <p style="text-align: center;"><b>RECEIVED JUN 23 2014 FACILITY STANDARDS</b></p>	
C 125	<p><b>02.100,03,c,ix Treated with Respect/Dignity</b></p> <p>ix. Is treated with consideration, respect and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; This Rule is not met as evidenced by: Please refer to F241 as it relates to dignity.</p>	C 125	<p><b>C125</b> Refer to F241</p>	<b>6/27/14</b>
C 159	<p><b>02.100,09 RECORD OF PTNT/RSDNT PERSONAL VALUABLES</b></p> <p>09. Record of Patient's/Resident's Personal Valuables. An inventory and proper accounting shall be kept for all valuables entrusted to the facility for safekeeping. The status of the inventory shall be available to the patient/resident, his conservator, guardian, or representative for review</p>	C 159	<p><b>C159</b></p> <p>Residents #15, 16, 17 were Discharged from facility prior to survey.</p> <p>All residents have the potential to be affected. Upon discharge all residents will have their Inventory List signed by the resident, family or POA. If resident</p>	<b>6/27/14</b>

Bureau of Facility Standards  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

*Executive Director*

(X6) DATE

*6/19/14*

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001080</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/23/2014</b>
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NAME OF PROVIDER OR SUPPLIER  <b>BRIDGEVIEW ESTATES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1828 BRIDGEVIEW BOULEVARD TWIN FALLS, ID 83301</b>
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C 159	<p>Continued From page 1</p> <p>upon request.</p> <p>This Rule is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure resident belongings were accounted for when discharged. This affected 3 of 3 (#s 15, 16 &amp; 17) closed records reviewed. Findings included:</p> <p>1. Resident #15 was admitted to the facility on 4/21/14 with diagnoses including congestive heart failure and chronic obstructive pulmonary disease. The resident was discharged to the hospital on 5/5/14.</p> <p>On 5/22/14 at 11:00 AM, the MRD (Medical Records Director) was interviewed by the surveyor about the resident's Inventory List in the medical record. She stated the Inventory List had not been filled out when the resident was discharged to the hospital.</p> <p>2. Resident #16 was admitted to the facility on 3/19/14 with multiple diagnoses including pneumonia and prostate cancer. The resident expired in the facility on 3/20/14.</p> <p>On 5/22/14 at 11:00 AM, the MRD (Medical Records Director) was interviewed by the surveyor and stated she did not find an Inventory List in the chart or in their filing. She stated she did not have verification the resident's belongings were delivered to the family in the nursing progress notes or the social services progress notes.</p> <p>3. Resident #17 was admitted to the facility on 3/21/14 with multiple diagnoses including history of fall, after care for healing of fractured hip, and esophageal reflux disease. The resident expired</p>	C 159	<p>does not wish to sign, this will be documented in the medical record. Audits are being completed to ensure compliance.</p> <p>Staff in-serviced to ensure that upon discharge either the resident, a family member or POA must sign the Inventory List or a note placed in the medical record as to the placement of their items.</p> <p>ED or designee will audit all discharges within 72 hours of discharge for facility accounting for residents belongings upon discharge starting 6/23/14. Audits will continue for six months. Results of the audit will be reviewed with the ED/DON and taken to PI monthly meeting starting with July meeting.</p>	

Bureau of Facility Standards

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C 159	Continued From page 2 in the facility on 4/9/14.  On 5/22/14 at 11:35 AM, the MRD was interviewed by the surveyor and stated she did not have a belonging's list in the chart or in their filing. She stated she had checked with the social services director and she didn't have a belonging's list. The MRD stated, "I don't have a belonging's list."  On 5/22/14 at 7:00 PM, the DON was made aware of the resident's disposition of belongings. The facility did not provide any additional information.	C 159		
C 175	02.100,12,f Immediate Investigation of Incident/Injury  f. Immediate investigation of the cause of the incident or accident shall be instituted by the facility administrator and any corrective measures indicated shall be adopted. This Rule is not met as evidenced by: Please refer to F225 as it relates to investigations.	C 175	<b>C175</b> Refer to F225	<b>6/27/14</b>
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: Please refer to F-371 as it relates to sanitary	C 325	<b>C325</b> Refer to F371	<b>6/27/14</b>

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C 325	Continued From page 3 conditions.	C 325	<b>C763</b>	<b>6/27/14</b>
C 763	<p>02.200,02,c,iii When Average Census 90 or More</p> <p>iii. In SNFs with an average occupancy rate of ninety (90) or more patients/residents a registered professional nurse shall be on duty at all times.</p> <p>This Rule is not met as evidenced by: Based on review of a three week nursing schedule and staff interview, it was determined the facility did not ensure a Registered Nurse (RN) was on duty at all times when the facility census was 90 or more residents. Findings include:</p> <p>Nursing Schedules from 4/27/14 through 5/17/14 were reviewed. The schedules did not include RN coverage on the night shift when the census was 90 or above on 4/28/14 and 4/29/14.</p> <p>On 5/22/14 at 4:20 PM, the DNS was informed related to the lack of RN coverage for the above dates and shifts. The DNS confirmed there was inadequate coverage and stated, "I am just a phone call away." The surveyor explained to the DNS the regulation related to RN staffing requirements for a census of 90 residents or higher. The DNS stated, "I know."</p> <p>On 5/22/14 at 4:30 PM, review of daily staffing sheets, confirmed the facility did not have Registered Nurse coverage on the night shift for the above dates. No additional information was provided to resolve this concern.</p>	C 763	<p>Residents #1-20 all residents who reside in the building will have RN on duty for all three shifts when census is at 90 or above.</p> <p>All residents who reside in the building have the potential to be affected. When census is at 90 or above an RN will be on duty for all three shifts. Audits are being completed to ensure compliance.</p> <p>Staff in-serviced on ensuring that when census is at 90 or above an RN must be on duty for all three shifts. Staff were in-serviced that if an RN cannot be found prior to shift they must inform DON.</p> <p>DON will audit schedule two times weekly for two months, weekly times two months and monthly times two months to ensure there is RN on duty for all three shifts when census is 90 and above. Audits will begin 6/23/14. Results of the audits will be taken to the PI monthly meeting starting with July meeting for six months.</p>	<b>6/27/14</b>
C 787	02.200,03,b,iii Fluid/Nutritional Intake	C 787	<b>C787</b> Refer to F312	<b>6/27/14</b>
	iii. Adequate fluid and nutritional			

Bureau of Facility Standards

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C 787	Continued From page 4  intake, including provisions for self-help eating devices as needed; This Rule is not met as evidenced by: Please refer to F312 as it relates to nutritional intake.	C 787		
C 789	02.200,03,b,v Prevention of Decubitus  v. Prevention of decubitus ulcers or deformities or treatment thereof, if needed, including, but not limited to, changing position every two (2) hours when confined to bed or wheelchair and opportunity for exercise to promote circulation; This Rule is not met as evidenced by: Refer to F314 for prevention of suspected deep tissue injuries.	C 789	<b>C789</b> Refer to F314	<b>6/27/14</b>
C 790	02.200,03,b,vi Protection from Injury/Accidents  vi. Protection from accident or injury; This Rule is not met as evidenced by: Refer to F323 as it relates to fall preventions and safety assessments.	C 790	<b>C790</b> Refer to 323 <b>F323</b> <i>per phone conversation w/ DNS on 7/15/14 at 11:05AM. BP</i>	<b>6/27/14</b>
C 879	02.203 PATIENT/RESIDENT RECORDS  203. PATIENT/RESIDENT RECORDS. The facility maintains medical records for all patients/residents in accordance with accepted professional standards and practices. This Rule is not met as evidenced by: Refer to F 514 as it relates to medical records.	C 879	<b>C879</b> Refer to F514	<b>6/27/14</b>

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C 881	Continued From page 5	C 881		
C 881	02.203,02 INDIVIDUAL MEDICAL RECORD  02. Individual Medical Record. An individual medical record shall be maintained for each admission with all entries kept current, dated and signed. All records shall be either typewritten or recorded legibly in ink, and shall contain the following: This Rule is not met as evidenced by: Please refer to F-514 as it relates to documentation.	C 881	<b>C881</b> Refer to F514	<b>6/27/14</b>
C 882	02.203,02,a Resident Identification Requirements  a. Patient's/resident's name and date of admission; previous address; home telephone; sex; date of birth; place of birth; racial group; marital status; religious preference; usual occupation; Social Security number; branch and dates of military service (if applicable); name, address and telephone number of nearest relative or responsible person or agency; place admitted from; attending physician; date and time of admission; and date and time of discharge. Final diagnosis or cause of death (when applicable), condition on discharge, and disposition, signed by the attending physician, shall be part of the medical record.  This Rule is not met as evidenced by: Based on record review and staff interview, it was determined the facility did not document the final diagnosis or cause of death. This was true for 1 of 3 (#16) sampled residents for review of closed	C 882	<b>C882</b>  Resident #16 expired prior to survey.  All residents who die have the potential to be affected. Facility will obtain the final diagnosis or cause of death from MD. Audits are being completed to ensure compliance.  Medical Records staff in-serviced that they must obtain the final diagnosis or cause of death and place it in the residents medical record prior to closing the medical record.  DON or designee will audit starting 6/23/14 all expirations to ensure final diagnosis or cause of death is in the medical record. Results of the audits will be reviewed with the ED/DON and	<b>6/27/14</b>

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C 882	<p>Continued From page 6 records. Findings included:</p> <p>Resident #16 was admitted to the facility on 3/19/14 with multiple diagnoses including pneumonia and prostate cancer. The resident expired in the facility on 3/20/14.</p> <p>On 5/22/14 at 11:00 AM, the MRD (Medical Records Director) was interviewed by the surveyor and stated, "there is not a cause of death in the chart."</p> <p>On 5/22/14 at 7:00 PM, the DON was informed of the final diagnosis or cause of death concern. No further information was provided by the facility.</p> <p>On 5/27/14 additional information was received from the facility that did not resolve this concern.</p>	C 882	taken to PI monthly meeting starting with the July meeting.	



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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

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

July 8, 2014

Jed W. Gines, Interim Administrator  
BridgeView Estates  
1828 Bridgeview Boulevard  
Twin Falls, ID 83301-3051

Provider #: 135113

Dear Mr. Gines:

On **May 23, 2014**, a Complaint Investigation survey was conducted at BridgeView Estates. Amy Barkley, R.N., Becky Thomas, R.N., Lauren Hoard, R.N. and Sherri Case, L.S.W., Q.M.R.P. conducted the complaint investigation. This complaint was investigated during the annual Recertification and State Licensure survey conducted May 19, 2014 through May 23, 2014.

The following documents were reviewed:

- The identified resident's record and the records of nine other sampled residents.
- Grievances for August of 2013 and December 2013 to May 2014.

Observations were made throughout the survey. Residents, residents' representatives and facility staff, which include Certified Nurse Aids (CNAs), were interviewed.

The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00006173**

**ALLEGATION #1:**

The complainant stated the resident had not been seen by a physician for the past five months.

FINDINGS:

The identified resident's record and the nine other sampled residents' records included documentation that these residents had been seen by a physician in accordance with the federal requirement.

Four individual residents were interviewed related to being seen by their physician routinely and as needed. All four residents stated they are seen by their physician regularly, and more often if needed.

Two family members or responsible party was interviewed and none indicated that there was a problem with the resident being seen by his or her physician.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The complainant reported that the identified resident was moved from one room to another without the move being discussed with the resident. The resident did not want to move, because she had a phone in the other room and now does not.

FINDINGS:

Grievances were reviewed and did not document any concerns related to residents being moved without prior notice.

Resident Council Meeting minutes were reviewed and did not document any concerns related to room changes.

The identified resident was interviewed on May 22, 2014, at 5:35 p.m. She stated that staff talked to her about the room change a couple of months prior to moving her. The resident also said she was able to choose the color she wanted the room painted; the facility re-tiled the floor, put a new shower in the bathroom, put new curtains up and took down a partition in the room to make the resident's room larger to accommodate her wheelchair and bed.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

### ALLEGATION #3:

The complainant reported the resident wears incontinent brief and had to sit in the wet brief for up to three hours.

### FINDINGS:

On May 20, 2014, the following was observed:

- 2:00 p.m.: the resident was observed sitting in her wheelchair, at the end of her bed, facing the door. A visibly wet bath blanket was on the floor under the resident's wheelchair.
- 2:15 p.m.: the resident was observed sitting in her wheelchair with a visibly wet bath blanket on the floor under the resident's wheelchair. The surveyor observed urine dripping off the resident's wheelchair onto the blanket and the bare floor under the resident. The resident's pants from her upper thighs to her waistband in the front was saturated with urine. The back of her pants from her buttocks to her waistband was saturated with urine and the bottom one third of the resident's shirt was wet from urine. The Hoyer sling and the wheelchair cushion underneath the resident was saturated with urine.
- 2:20 p.m.: the surveyor asked the resident why the bath blanket was on the floor under her wheelchair. The resident stated she told the CNA between 1:30 p.m. and 1:45 p.m. she needed to use the bedpan. The CNA informed the resident she needed to get another CNA to assist with transferring the resident from the resident's wheelchair to the bed. The resident stated the CNA left to find help and by 1:55 p.m. when no one returned, the resident voided in her pants. The resident stated she saw the CNA who was supposed to be finding another CNA to help transfer her for toileting across the hall assisting another resident. The resident pushed her call light for assistance. The same CNA returned to the resident's room, saw the wet area under the resident's wheelchair and put a bath blanket on top of the urine. The resident stated she understood it took two staff to toilet her but she should not have to wait 25-30 minutes or longer. The resident told the surveyor this happens several times during the week and she ends up voiding in her pants before she is toileted.

This allegation was substantiated, and the facility was cited at F241 for failure to maintain a resident's dignity.

### CONCLUSIONS:

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

ALLEGATION #4:

The complainant reported that the resident told the facility he or she wanted to go home. The complainant stated the resident was not receiving the care she needed, including physical therapy.

FINDINGS:

The identified resident's Minimum Data Set (MDS) assessment was reviewed. The MDS assessment documented the resident was total dependence for transfers via Hoyer sling and required two-person extensive assist with showering, bed mobility and toileting.

Physical Therapy notes were reviewed. The Physical Therapy notes documented the resident had reached her maximum rehabilitation potential; however, she was participating with restorative nursing.

Progress notes were reviewed and did not contain documentation that the resident had any concerns related to participation in therapies.

Care Plans were reviewed. A care plan documented "Social Services to keep the ombudsman involved and updated regarding resident's situation. Social Services will work with the resident on contacting other facilities regarding bed availability as needed."

Grievances were reviewed and did not contain documentation of concerns related to resident's having a difficult time with discharge planning.

Social Services was interviewed and stated that the facility had attempted per the resident's request to find another facility for the resident to transfer to.

The ombudsman was interviewed and stated she notified the resident about other facilities in the area and the resident declined.

The surveyor interviewed the resident related to transferring to a different facility and the resident stated she was happy where she was and that the facility had made several changes to her room per her request.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

Based on the findings of the complaint investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this

Jed W. Gines, Interim Administrator  
July 8, 2014  
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complaint's findings letter, as it will be addressed in the provider's Plan of Correction.

If you have questions, comments or concerns regarding our investigation, please contact Lorene Kayser, L.S.W., Q.M.R.P. or David Scott, R.N., Supervisors, Long Term Care at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

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

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

LKK/dmj



IDAHO DEPARTMENT OF  
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July 8, 2014

Jed W. Gines, Interim Administrator  
BridgeView Estates  
1828 Bridgeview Boulevard  
Twin Falls, ID 83301-3051

Provider #: 135113

Dear Mr. Gines:

On **May 23, 2014**, a Complaint Investigation survey was conducted at BridgeView Estates. Amy Barkley, R.N., Becky Thomas, R.N., Lauren Hoard, R.N. and Sherri Case, L.S.W., Q.M.R.P. conducted the complaint investigation. This complaint was investigated in conjunction with the facility's annual Recertification and State Licensure survey conducted May 19 through May 23, 2014.

The following documentation was reviewed:

- The medical records of ten residents currently residing at the facility and one discharged resident, includes five sampled residents who used oxygen;
- Grievances for the previous six months;
- Accidents and incident reports for the previous six months; and,
- Investigations of alleged abuse.

The following individuals were interviewed:

- Ten residents that attended a group meeting with the surveyors;
- Four residents that were interviewed individually;
- Two family members.

The following personnel were interviewed:

Jed W. Gines, Interim Administrator  
July 8, 2014  
Page 2 of 4

- Licensed Nurses (LNs)
- Certified Nurse Aides (CNAs)
- Director of Nursing (DoN)
- Administrator; and
- Therapists.

Observations of care provided were made throughout the survey.

The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00006463**

**ALLEGATION #1:**

The complainant stated that residents are not provided assistance to eat when it is needed.

**FINDINGS:**

During an evening meal observation, three residents were observed not to receive adequate assistance to eat their meals.

The facility was cited at F312 for failure to provide assistance with dining.

**CONCLUSIONS:**

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

**ALLEGATION #2:**

The complainant stated a resident did not receive oxygen therapy as ordered by the physician and "turned purple."

**FINDINGS:**

Medical records of five sampled residents and the identified discharged resident were reviewed. All the medical records included physician's orders for oxygen and documentation of the resident's saturation levels. The nurses' notes in the medical records did not document any concerns regarding the residents use of oxygen or low saturation levels.

Observations were completed throughout the survey for the five sampled residents to ensure oxygen orders were followed in accordance to their physician's orders. The five residents were

observed throughout the survey with their oxygen on and the liter flow at the rate ordered by their physician.

The five sample residents' medical records and the identified discharged resident's closed record did not document low oxygen saturation levels.

There were no grievances or incident reports that documented concerns regarding residents' oxygen saturation levels.

Two licensed nurses were interviewed, and one of them stated he/she could remember someone reporting concerns regarding the identified resident's saturation levels; but, when he/she checked the resident, the saturation level was fine. The other nurse stated he/she "could not think of anything or any event."

#### CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

#### ALLEGATION #3 :

The complainant stated:

- Residents were made to get up early in the morning without regard to their preference.
- Therapy services did not allow residents to change their scheduled time, if requested.
- Staff was abrupt in the care they provided and did not provide proper body support for the residents.
- Staff did not treat residents respectfully.

#### FINDINGS:

During observations on varying shifts throughout the survey, staff was observed to treat residents respectfully and provide cares appropriately.

Ten residents attending the group meeting stated they had no concerns regarding staff treating them with respect, and the residents were allowed to get up in the morning when they wanted. The residents had no concerns with "feeling safe" when staff transferred them, did not express any concerns about staff providing proper body support or staff being "abrupt" when providing care. The residents stated they have never witnessed residents who lacked communication skills being treated disrespectfully. The residents stated therapists would change the time of their scheduled therapy, if requested.

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Residents and family members who were interviewed privately did not express any concerns regarding any of the identified issues.

The supervisor for therapy and two therapists were interviewed. They all stated that they frequently change the time of a resident's scheduled therapy at the resident's request.

Three LNs and six CNAs were interviewed regarding the complainant's concerns. One of the nine nursing staff interviewed expressed concern regarding a resident being "dropped" on his/her bed and told to stay in the bed. Grievances, accident/incident reports and the identified resident's record were reviewed and none contained documentation addressing the stated concern. Another staff member reported that the facility had investigated the above concerns at least six months ago and they had been resolved.

The Administrator and the DoN were interviewed individually regarding the complainant concerns, both stated the facility had investigated an allegations regarding staff treatment of residents. The investigation did not substantiate the allegation of abuse.

**CONCLUSIONS:**

Unsubstantiated. Lack of sufficient evidence.

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

If you have questions, comments or concerns regarding our investigation, please contact Lorene Kayser, L.S.W., Q.M.R.P. or David Scott, R.N., Supervisors, Long Term Care at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

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

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

LKK/dmj