



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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

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BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, ID 83720-0009  
PHONE 208-334-6626  
FAX 208-364-1888

CERTIFIED MAIL: 7012 1010 0002 0836 2465

July 25, 2013

Renae Oswald, Administrator  
Eastern Idaho Regional Medical Center - Transitional Care Unit  
3100 Channing Way, PO Box 2077  
Idaho Falls, ID 83403

Provider #: 135115

Dear Ms. Oswald:

On **July 11, 2013**, a Recertification and State Licensure survey was conducted at Eastern Idaho Regional Medical Center - Transitional Care Unit by the Department of Health & Welfare, 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

Rena Oswald, Administrator  
July 25, 2013  
Page 2 of 4

sign both 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 **August 7, 2013**. Failure to submit an acceptable PoC by **August 7, 2013**, may result in the imposition of civil monetary penalties by **August 27, 2013**.

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 you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will 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 has 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 5.

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.

Renae Oswald, Administrator  
July 25, 2013  
Page 3 of 4

- 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 **August 15, 2013 (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 **August 15, 2013**. A change in the seriousness of the deficiencies on **August 15, 2013**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **August 15, 2013** includes the following:

Denial of payment for new admissions effective **October 11, 2013**. [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 **January 11, 2014**, if substantial compliance is not achieved by that time.

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

If you believe these deficiencies have been corrected, you may contact Loretta Todd, R.N. or Lorene Kayser, L.S.W., Q.M.R.P., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0036; 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.

Rena Oswald, Administrator  
July 25, 2013  
Page 4 of 4

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 **July 11, 2013** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the noncompliance at the time of the revisit, if appropriate.

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

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

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

- BFS Letters (06/30/11)

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

This request must be received by **August 7, 2013**. If your request for informal dispute resolution is received after **August 7, 2013**, 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, please contact us at (208) 334-6626.

Sincerely,



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

LKK/dmj  
Enclosures

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

FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  07/11/2013
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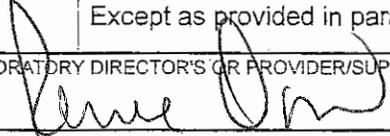
NAME OF PROVIDER OR SUPPLIER  EASTERN IDAHO REGIONAL MEDICAL CENTER - TCU	STREET ADDRESS, CITY, STATE, ZIP CODE 3100 CHANNING WAY, 83404 IDAHO FALLS, ID 83403
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the annual Federal recertification survey of your facility.</p> <p>The surveyors conducting the survey were: Karen Marshall, MS, RD, LD Team Coordinator Bradley Perry, BSW, LSW Linda Kelly, RN</p> <p>Survey Definitions: ADL = Activities of Daily Living CNA = Certified Nurse Aide DON = Director of Nursing E-MAR = Electronic Medication Administration Record LN = Licensed Nurse MD = Medical Doctor MDS = Minimum Data Set assessment PT = Physical Therapy RN = Registered Nurse T.B. = Tubercle Bacillus TCU = Transitional Care Unit</p> <p>F 164 SS=D 483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this</p>	F 000		
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**RECEIVED**  
**AUG - 7 2013**  
**FACILITY STANDARDS**

Please see page 2

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE NHA	(X6) DATE 08/06/2013
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 164	<p>Continued From page 1</p> <p>section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure residents were provided with privacy during cares. This was true for 1 of 5 sample residents (#5). The failed practice created the potential for a negative affect on the resident's psychosocial well-being. Findings included:</p> <p>On 7/10/13 at 9:15 a.m., during a medication (med) pass observation, LN #3 administered 10 oral meds and a subcutaneous injection of Lovenox, an anticoagulant, to Resident #5. After the oral meds were administered, the LN raised the resident's patient gown and administered the injection into the resident's right lower abdomen. The door to the room was wide open while the right side of the resident's abdomen was uncovered.</p>	F 164	<ol style="list-style-type: none"> <li>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident # 5 has been discharged from the facility.</li> <li>2. 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? All TCU residents have the potential to be affected.</li> <li>3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? When DON was notified of the event on 7/11/13 she verbally communicated with the TCU staff to close the residents' door when administering injections. Additionally, LN #3 was counseled by DON regarding resident privacy. Education regarding resident privacy was provided at the July 23<sup>rd</sup> and 25<sup>th</sup> staff meetings.</li> <li>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? During daily rounding done by charge nurses and weekly rounding done by leadership team, resident privacy will be monitored and corrective action implemented if a breach in privacy occurs. This item has been highlighted on the rounds reports and will be audited for completion on a weekly basis x 4 weeks, and then monthly on an ongoing basis beginning on 8/1/13.</li> </ol>	8/14/13
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/27/2013  
FORM APPROVED  
OMB NO. 0938-0391

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F 164	Continued From page 2 At 9:30 a.m., when informed of the aforementioned observation, LN #3 stated, "Normally I do close the door."  On 7/11/13 at 2:25 p.m., the DON was informed of the observation. No other information or documentation was received from the facility that resolved the issue.	F 164		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY  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 observations and resident interview, it was determined the facility failed to maintain resident's dignity by exposing a resident's buttock, thigh, and torso in the resident's room with the door open and staff failed to knock on a resident's door while cares were being given. This was true for 2 of 7 (#4 & #5) sampled residents. This created the potential for a negative effect on the resident's self-esteem. Findings include:  1. On 7/9/13 from 3:20-3:27 PM, Resident #5 was observed in her private room with the hallway door wide opened, lying on her back in her bed, without a sheet covering her and wearing a hospital type gown. The gown was open in the back and to the side which exposed her left flank and revealed approximately five inches of her left buttock and upper thigh. During this observation a male visitor, visiting a different resident, walked	F 241	Please see page 4	

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F 241	<p>Continued From page 3</p> <p>by Resident #5's opened doorway two times. Two other surveyors also walked by the room. RN #1 walked by the room, but did not appear to notice the resident's exposed skin.</p> <p>At 3:33 PM, Resident #5 was observed in her room, on her phone lying on her right side which exposed approximately six inches of her upper left thigh, buttock, and torso up to her armpits. During this observation an additional surveyor witnessed the resident, however, RN #1 and PT Assistant #2 also walked by the room but did not appear to notice the resident's exposed skin. At 3:39 PM, the resident was observed lying on her back and covered by her gown.</p> <p>On 7/10/13 at 7:50 AM, the resident was interviewed regarding privacy issues. She said she liked having her door opened, but stated, "The hospital gowns have a lot to be desired."</p> <p>On 7/11/13 at 10:40 AM, the DON was notified of the dignity issue. No other information was provided by the facility.</p> <p>2. On 7/10/13 from about 7:15 a.m. to 7:30 a.m., LN #4 and LN #5 were observed as they assisted Resident #4 to use a bedside commode chair. The commode chair was positioned by the resident's bed on the door side of the room.</p> <p>At 7:25 a.m., without knocking, LN #3 opened the resident's door and stuck her head into the room. LN #3 asked the other 2 LNs if they needed help and both of them said, "No." Resident #4, who was on the commode chair at the time, looked up and frowned at LN #3 during the interchange between the 3 LNs.</p>	F 241	<ol style="list-style-type: none"> <li>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident # 5 has been discharged from the facility.</li> <li>2. 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? All TCU residents have the potential to be affected.</li> <li>3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? DON provided corrective counseling to LN #3 regarding knocking on door and obtaining permission before entering resident rooms. Education regarding resident privacy, including knocking prior to entering residents' rooms was provided to all TCU staff at the July 23<sup>rd</sup> and 25<sup>th</sup> staff meetings.</li> <li>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? During daily rounding done by charge nurses and weekly rounding done by leadership team, resident privacy will be monitored and corrective action implemented if a breach in privacy occurs. This item has been highlighted on the rounds reports and will be audited for completion on a weekly basis x 4 weeks, and then monthly on an ongoing basis beginning on 8/1/13.</li> </ol>	8/14/13	

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F 241	Continued From page 4  NOTE: All of the resident rooms on the TCU had a sign on the outside of the door that said to knock before entering.	F 241		
F 252 SS=D	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT  The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.  This REQUIREMENT is not met as evidenced by: Based on observation and resident interview, it was determined the facility failed to provide a homelike environment by serving meals to residents on trays. This affected 2 of 2 random residents (#s 9 & 10) and had the potential to affect any resident served meals in the dining/recreation room. This practice created the potential to negatively affect the residents' psychosocial well-being related to a comfortable and homelike environment. Findings included:  On 7/10/13 at 12:12 p.m. and on 7/11/13 at 12:10 p.m., both Random Residents #s 9 and 10 were observed dining in the dining/recreation room with their meals served on trays. The residents' plates of food, cups, and utensils were not removed from their trays while the residents	F 252	<ol style="list-style-type: none"> <li>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Residents #9 &amp; 10 have been discharged from the facility.</li> <li>2. 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? All TCU residents have the potential to be affected.</li> <li>3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? All TCU staff members (including therapy staff) were immediately notified that residents' plates, cups, and utensils must be removed from trays while the residents are dining. Additionally, education was provided to all TCU staff at the July 23<sup>rd</sup> and 25<sup>th</sup> staff meetings.</li> <li>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The practice of removing residents' meals from their trays will be monitored on a daily basis by the TCU charge nurse. Any breach in practice will be immediately corrected and reported to the DON for further corrective counseling.</li> </ol>	8/14/13

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F 252	Continued From page 5 were dining.  On 7/10/13 at approximately 2:14 p.m., Random Resident #9 stated, "I eat lunch in the dining room. My food is always served on trays."  On 7/11/13 at 2:25 p.m., the DON was informed of the observations. The facility did not provide any additional information.	F 252		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS  A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.  The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.  The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).  This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure care	F 279	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Residents #2 & 4 have been discharged from the facility. 2. 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? All TCU residents have the potential to be affected.  Continued	8/14/13

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F 279	<p>Continued From page 6</p> <p>plans were updated for as needed (PRN) medications and nutrition interventions. This affected 2 of 7 (#s 2 &amp; 4) sampled residents. The practice created the potential for unmet needs due to lack of direction in the care plans. Findings included:</p> <p>1. Resident #4 was admitted to the facility on 7/5/13 with multiple diagnoses including chronic kidney failure.</p> <p>Resident #4 did not yet have a comprehensive MDS completed as of the date of the survey.</p> <p>The resident's 7/5/13 Admission Orders did not include an order for Ativan or Ambien.</p> <p>The resident's medical record contained what appeared to be handwritten physician's orders: - 7/6/13, Ambien 5 milligram by mouth every night as needed (5 mg PO q hs prn) for sleep/insomnia - 7/8/13, Ativan 0.5 mg - 1 mg PO every 6 hours prn for anxiety</p> <p>Review of the facility's electronic database did not provide evidence Ativan and Ambien were care planned.</p> <p>Review of the facility's electronic database provided evidence the resident was administered Ativan and Ambien as ordered. However, the electronic database did not provide evidence nursing staff monitored the efficacy of Ativan or the hours of sleep for Ambien. Please refer to F329.</p> <p>On 7/11/13 at 10:25 a.m., the surveyor informed the DON the resident's use of Ativan and Ambien</p>	F 279	<p>3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? DON immediately added the Behavior Monitoring intervention and Hours of Sleep interventions to Resident # 4's plan of care. Charge nurses will be responsible to add these interventions to the POC when a resident is admitted with orders for psychoactive medications. Additionally, the MDS Coordinator will be responsible for reviewing each resident's POC weekly and adding any additional interventions to the POC. The Registered Dietician will add their interventions (i.e. snacks, protein-packed meals) to the residents' POC on an ongoing basis. Education regarding this deficiency was provided to all TCU staff at the July 23<sup>rd</sup> and 25<sup>th</sup> staff meetings.</p> <p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The MDS Coordinator will complete a weekly sample roster of each resident's POC along with the interventions that have been included in the POC, and return it to the DON for review. Any additional necessary interventions will be added to the resident's POC by the DON at that time.</p>		

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NAME OF PROVIDER OR SUPPLIER  EASTERN IDAHO REGIONAL MEDICAL CENTER - TCU			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 CHANNING WAY, 83404 IDAHO FALLS, ID 83403		
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F 279	<p>Continued From page 7 .</p> <p>were not care planned. The DON acknowledged the medications were not care planned.</p> <p>2. Resident #2 was admitted to the facility on 6/4/13 with multiple diagnoses including diabetic wound and sepsis. The resident was admitted from the local hospital wing after surgery for a diabetic wound.</p> <p>Resident #2's 6/16/13 admission MDS coded: cognitively intact, required set up help for dining, weight 189 pounds, and height 70 inches (5 foot 10 inches).</p> <p>The resident's weight was documented in the facility's electronic database as 200 pounds on 6/4/13 and 176 pounds on 7/1/13. This represented a severe weight loss of 24 pounds, 12 percent in 27 days.</p> <p>Review of the Registered Dietitian's (RD) Nutrition Assessments revealed the RD spoke with the resident and interventions were put into place as follows:</p> <ul style="list-style-type: none"> <li>- 6/5/13, Appetite fine, (Resident #2) said meals have been fine, received calculated American Diabetes Association diet 2209 kilocalories and 96 grams protein</li> <li>-6/17/13, has been hungry between meals, added snacks two times a day, weight changes may be related to different scales used as intakes have been fair but stable</li> <li>-7/1/13, intakes fair, continued snacks two times a day (BID), changed from non-select menu to menu assist to promote increased intake with choosing desired meals</li> </ul> <p>On 7/10/13 at 11:55 a.m., Resident #2 verified the</p>	F 279			

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F 279	Continued From page 8 RD's recommendations as identified above were implemented by the facility. The resident stated, "I know I have lost weight. I needed to because of my condition."  Review of the facility's electronic database did not provide evidence the resident's care plan was updated to include the RD's recommendations as identified above: 2209 kilocalories, snacks BID, and changed from non-select menu to menu assist to promote increased intake.  On 7/11/13 at 1:52 p.m., the surveyor informed the DON the RD's recommendations, although implemented, were not included in the resident's care plan maintained in the electronic database. The DON stated, "Our plans of care are different. We implemented increased calories, the snacks BID, and we allowed the resident to choose foods from the select menu. I do not agree with this citation at F279 as we did the interventions as the RD recommended."	F 279			
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER  Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.  This REQUIREMENT is not met as evidenced	F 315	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident # 5 has been discharged from the facility.  2. 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? All TCU residents with an indwelling catheter have the potential to be affected.  Continued	8/14/13	

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F 315	<p>Continued From page 9</p> <p>by:</p> <p>Based on observation, staff and resident interviews and record review, it was determined the facility did not ensure an indwelling catheter was only used when clinically indicated and failed to develop a catheter care plan and treatment sheets to document catheter care for 1 of 7 sampled residents (#5). The resident did not have a clinical diagnosis for the use of the indwelling catheter. This failed practice had the potential to harm the resident if she developed urinary tract infections or other complications related to an indwelling catheter. Findings include:</p> <p>Resident #5 was admitted to the facility on 7/6/13 with multiple diagnoses including left hip fracture, atrial fibrillation and congestive heart failure.</p> <p>On 7/9/13 at 3:27 PM, the resident was observed in her room on her bed with catheter tubing running into a catheter bag attached to the side of her bed in a privacy cover.</p> <p>A local hospital's Urinary Catheter record for the resident, documented on 7/3/13 at 6:31 AM, "Urinary catheter type: Temporary Indwelling".</p> <p>The resident's Admission Orders dated 7/5/13 under the heading "Therapy Orders" contained a check box for foley (catheter) care, which was not checked.</p> <p>The resident's handwritten Telephone Physician's Orders dated 7/7/13 documented, "Keep foley for accurate I &amp; O's (intakes and outputs)."</p> <p>The resident's admission assessment dated 7/7/13 at 12:43 PM, documented, "Foley: Yes".</p>	F 315	<p>3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? DON immediately added the Indwelling Catheter intervention to the resident's plan of care.</p> <p>All residents admitted to TCU will have their indwelling catheter removed unless the physician has documented medical necessity for it to remain. Charge nurses will be responsible to add this intervention to the POC if a resident is admitted with orders for an indwelling catheter. Additionally, the MDS Coordinator will be responsible for reviewing each resident's POC weekly and adding any additional interventions to the POC. Education regarding this deficiency was provided to all TCU staff at the July 23<sup>rd</sup> and 25<sup>th</sup> staff meetings.</p> <p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The MDS Coordinator will complete a weekly sample roster of each resident's POC along with the interventions that have been included in the POC, and return it to the DON for review. Any additional necessary interventions will be added to the resident's POC by the DON at that time.</p>		

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F 315	Continued From page 10  NOTE: No Care Plan was found in the resident's medical record or electronic database regarding the catheter.  On 7/10/13 at 3:30 PM, the DON was interviewed regarding the lack of a catheter care plan. She stated, "She [Resident #5] doesn't have an intervention for foley cath[eter]... I will add that to the plan of care now."  On 7/11/13 at 8:40 AM, the DON was interviewed further to see if catheter care was being done for Resident #5 and she said the facility follows the Lippincott nursing manual and stated, "I'm assuming it's being done." She also said, since a care plan was not set up in the facility computer system, there was no place for nurses to document when or what catheter care was provided for the resident. At approximately 9:00 AM, the DON provided the surveyor a copy of Lippincott's Nursing Procedures and Skills for indwelling urinary catheter (foley) care and management and a copy of the facility Genital Urinary System policy dated 3.13 (March 2013). The policy did document, "Provide catheter care every shift (see Lippincott for procedure)."  On 7/11/13 at 10:55 AM, the DON was interviewed regarding the medical justification for the catheter. After viewing the orders and the resident's medical record she stated, "I don't see where he [Resident #5's Physician] justified it...it's not documented why she needs it."  On 7/11/13 at 12:05 PM, the resident was interviewed regarding the catheter. She said she had not asked or been told when the catheter	F 315			

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F 315	Continued From page 11 was to be taken out and had not had any pain or urinary tract infections related to the indwelling catheter.	F 315		
F 328 SS=E	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS  The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.  This REQUIREMENT is not met as evidenced by: Based on record review, observation, and resident and staff interview, it was determined the facility failed to ensure oxygen (O2) treatments and therapy were accurately administered and O2 orders had appropriate parameters. This affected 4 of 8 (#s 2, 5, 6, & 8) residents sampled for O2 therapy. This practice created the potential for harm as too little oxygen in the bloodstream may result in hypoxemia or shortness of breath and too much oxygen (oxygen toxicity) may result in central nervous system disturbances, coma, or death. Findings included:	F 328	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Residents # 2, 5, and 8 have been discharged from the facility. 2. 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? All TCU residents receiving oxygen have the potential to be affected. 3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? On July 31, 2013, the TCU medical director clarified use of oxygen titration orders for TCU. A standing order is in place that reads "may titrate O2 to achieve physician ordered O2 saturation; call physician if O2 requirement is > 4 liters per minute." Education was provided to all TCU nursing staff at the July 23 <sup>rd</sup> and 25 <sup>th</sup> staff meetings.  Continued	8/14/13

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F 328	<p>Continued From page 12</p> <p>1. Resident #2 was admitted to the facility on 6/4/13 with multiple diagnoses including diabetic wound and sepsis. The resident was admitted from the local hospital wing after surgery for a diabetic wound.</p> <p>The resident's 6/16/13 admission MDS coded cognitively intact, no delirium, received O2 therapy. Section V triggered for dehydration and fluid maintenance.</p> <p>The resident's 6/5/13 Admission Orders included, in part, "...O2 liter flow 2 adjust to maintain sats &gt;90% [liter flow 2 liters per minute (LPM) adjust liter flow to maintain O2 saturations greater than 90%]."</p> <p>The interventions, for the resident, in the facility's electronic database included, in part, "Oxygen 2 LPM per NC [nasal cannula] to keep sats &gt;92%."</p> <p>The resident's medical record contained what appeared to be a 6/5/13 handwritten physician's order, "O2 keep sats &gt;92%."</p> <p>NOTE: The oxygen order on the resident's Admission Orders and the oxygen order in the electronic database were conflicting and unclear as to how the O2 was to be administered, continuous or as needed (prn). In addition, the 6/5/13 handwritten order did not include the parameters for oxygen administration.</p> <p>On 7/10/13 at 3:40 p.m., the surveyor informed the DON the resident's oxygen orders did not include parameters [lower and upper] for oxygen administration and were unclear as to how the O2</p>	F 328	<p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Oxygen orders and requirements will be reviewed on all O2 dependent residents weekly at the interdisciplinary team meeting. If the O2 requirement is &gt; than 4 LPM, an audit of the physician's orders will be performed by the MDS Coordinator to validate whether an order for that liter flow is present. Appropriate O2 settings and orders for O2 will also be audited for daily charge nurse rounds and weekly leadership rounds. Results of these audits will be submitted to the DON for review on a weekly basis with follow up corrective action as needed.</p>		

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F 328	<p>Continued From page 13</p> <p>was to be administered. The DON stated, "This is how we monitor O2 sats and administer O2 for this resident. We start on room air. We monitor Resident #2's oxygen saturation levels. We can adjust O2 to 2 LPM to keep sats &gt;90% according to the current orders. If we can't maintain saturations &gt;90% on 2 LPM, we call the MD. The word "adjust" on the Admission Orders implies we can increase or decrease the O2 liter flow or administer the O2 as needed [PRN]."</p> <p>On 7/10/13 at 4:00 p.m., Resident #2 stated, "I do not remember having to wear O2 tubing since being here."</p> <p>On 7/11/13 at 1:52 p.m., the surveyor and the DON again spoke about the oxygen orders for those residents who had O2 ordered. The DON stated, "I do not believe we need a lower limit [lower parameter] for the O2 liter flow. I see the rationale for the upper limit [upper parameter]."</p> <p>Resident #2's O2 orders were conflicting. The orders were unclear whether the O2 was to be administered continuous, PRN, whether to maintain the resident's sats greater than 90% or greater than 92%, and what the O2 administration parameters were.</p> <p>2. Resident #6 was originally admitted to the facility on 5/13/13, and most recently readmitted on 6/13/13, with multiple diagnoses including chronic obstructive pulmonary disease and pneumonia.</p> <p>The resident's 6/25/13 admission MDS coded cognitively intact, no delirium, and received oxygen therapy. Section V did not trigger for</p>	F 328			

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

FORM APPROVED  
OMB NO. 0938-0391

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F 328	<p>Continued From page 14 dehydration or fluid maintenance.</p> <p>The resident's Admission Orders contained, in part, "O2 continuous liter flow 2 adjust to maintain sats &gt;90%."</p> <p>Resident #6's O2 administration documentation in the facility's electronic database revealed between 6/8/13 to 7/11/13, the resident was administered oxygen in the ranges from 1.75 LPM to 5.0 LPM.</p> <p>On 7/11/13 at 2:25 p.m., the surveyor informed the DON Resident #6's oxygen administration ranged from 1.75 LPM to 5 LPM. The DON nodded her head in an up and down motion indicating acknowledgement.</p> <p>3. Resident #8 was admitted to the facility on 5/28/13 with multiple diagnoses including syncope and congestive heart failure. The resident was discharged on 6/4/13.</p> <p>The resident's 5/28/13 Admission Orders contained, "O2 continuous liter flow 1 L [liter] adjust to maintain sats &gt;90% [O2 continuous liter flow at 1 LPM adjust to maintain sats &gt;90%]."</p> <p>Review of the resident's closed record located in the facility's electronic database provided evidence nursing staff administered O2 at two liters per minute on 5/29/13. The resident's O2 sats were recorded at 92%.</p> <p>On 7/11/13 at 9:25 a.m., the surveyor informed the DON the resident was administered O2 at 2 LPM on 5/29/13 although the order was for 1 LPM. The DON stated, "In this case, I would think</p>	F 328			

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F 328	Continued From page 15 if [Resident #8's sats] dropped below 90% we would have to call [the resident's physician]."  4. Resident #5 was admitted to the facility on 7/6/13 with multiple diagnoses including left hip fracture, atrial fibrillation and congestive heart failure.  The resident's Admission Orders dated 7/5/13 had a section titled "Oxygen", but the section was left blank.  The resident's handwritten Telephone Physician's Orders dated 7/7/13 documented, "O2 (oxygen) to keep sats (saturation) > (greater than) 90%." NOTE: The order did not contain what parameters the flow rate was to be set for or what type of oxygen delivery system should be used.  On 7/9/13 at 3:27 PM, the resident was observed in her room with oxygen delivered via nasal cannula.  On 7/11/13 at 10:50 AM, the DON was interviewed regarding the oxygen orders. After review of the admission orders, she stated, "It should have been on the admission order." When shown the telephone order and lack of parameters, she stated, "It's not a good order."  On 7/11/13 at 2:25 PM, the DON was informed of the oxygen issue. No further information was provided by the facility.	F 328			
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS  Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any	F 329			

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F 329	<p>Continued From page 16</p> <p>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.</p> <p>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.</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 residents did not receive unnecessary medications. This was true for 2 of 5 sample residents (#2 and #4). Resident #2 received 2 anti-depressant medications without clinical rationale for the duplicate therapy. Resident 4#'s PRN (as needed) anti-anxiety and hypnotic medications were not monitored for effectiveness. These failures created the potential to harm the residents because unnecessary medications can lead to adverse reactions and health decline.</p>	F 329	<ol style="list-style-type: none"> <li>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Residents #2 &amp; 4 have been discharged from the facility.</li> <li>2. 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? All TCU residents have the potential to be affected.</li> <li>3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? DON immediately added the Behavior Monitoring intervention and Hours of Sleep intervention to Resident # 4's plan of care. The Clinical Pharmacist, Debra Barton, spoke with resident # 2's physician regarding the duplicate anti-depressant Rx. The physician stated that Resident #2 had been on this Rx regimen for several years; he had discussed this in detail with the resident, and together they had decided to continue with this combination therapy as it had been successfully treating the depression. This information was added to the progress notes in the medical record by the pharmacist. The clinical pharmacist will continue to review all resident's medication regimen and contact the physician if/when duplicate therapies occur.</li> </ol> <p style="text-align: right;">Continued</p>	8/14/13	

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F 329	<p>Continued From page 17</p> <p>Findings included:</p> <p>1. Resident #4 was admitted to the facility on 7/5/13 with the diagnoses acute on chronic kidney disease, peripheral vascular disease, and coronary artery disease.</p> <p>Resident #4's Physician's Orders included:                      * 7/6/13 at 5:00 p.m. - Ambien at bedtime as needed for sleep/insomnia;                      * 7/7/13 at 3:15 p.m. - Ativan 0.5 - 1 milligram IV (1 mg intravenous) every 6 hours PRN for anxiety; and                      * 7/8/13 at 9:10 p.m. - Ativan 0.5 - 1 mg PO (by mouth) every 6 hours PRN for anxiety.</p> <p>Review of the E-MAR documentation revealed Resident #4's received:                      * PRN Ambien on 7/6/13 at 8:14 p.m., 7/7/13 at 8:23 p.m., and 7/8/13 at 7:55 p.m.;                      * PRN Ativan 1 mg IV on 7/7/13 at 4:27 p.m. and 8:16 p.m.;                      * PRN Ativan 0.5 mg IV on 7/8/13 at 7:13 a.m.; and                      * PRN Ativan 1 mg PO on 7/8/13 at 9:41 p.m., and 7/9/13 at 8:38 a.m. and 6:19 p.m.</p> <p>On 7/11/13 at 10:25 a.m., the DON was asked to provide documentation that Resident #4's PRN Ativan and Ambien were monitored for their efficacy. The DON stated, "We have a policy to start with the lowest dose." She indicated, however, that the efficacy of PRN Ativan was not documented as monitored. Regarding the Ambien, the DON stated, "We have an intervention for hours of sleep but it's not there. We just didn't do it."</p>	F 329	<p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The MDS Coordinator will complete a weekly sample roster of each resident, along with the interventions that have been included in the POC, and return it to the DON for review. Any additional necessary interventions will be added to the resident's POC by the DON at that time. After reviewing all residents' medication regimen, the clinical pharmacist will notify the DON of any duplicate therapies.</p>		

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F 329	<p>Continued From page 18</p> <p>2. Resident #2 was admitted to the facility on 6/4/13 with multiple diagnoses including Diabetes Mellitus.</p> <p>The resident's 6/16/13 admission MDS assessment coded cognitively intact and received anti-depressant medications in the past 7 days.</p> <p>The resident's 6/5/13 Active Hospital Medications (Physician's Orders) included:</p> <ul style="list-style-type: none"> <li>- 6/4/13, Lexapro 10 mg PO at bedtime for depression/anxiety</li> <li>- 6/4/13, Effexor XR (extended release) 150 mg PO BID (twice a day) for depression/anxiety</li> </ul> <p>Review of the resident's medical record and electronic database medical record revealed the resident was administered Lexapro and Effexor as ordered.</p> <p>NOTE: The medical record and electronic database did not provide clinical rationale for two medications from the same class, anti-depressant.</p> <p>On 7/10/13 at 1:40 p.m. the surveyor informed the DON of the resident receiving duplicate anti-depressant therapy and review of the resident's medical record did not provide evidence of a clinical rationale for duplicate therapy. The DON stated, "I will check with pharmacy as pharmacy reviews the residents' medications."</p> <p>On 7/11/13 at 1:52 p.m., the DON provided the surveyor with the pharmacist's review of Resident #2's duplicate anti-depressant therapy. The DON stated, "I anticipate the MD signing the pharmacist's note the next time the MD comes</p>	F 329			

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F 329	Continued From page 19 in."	F 329			
F 332 SS=D	<p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE</p> <p>The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and policy review, it was determined the facility failed to maintain a medication error rate less than 5 percent. This was true for 2 of 34 medications (5.88%) which affected 2 of 6 residents (#1 and #5) reviewed for medication administration practices. The failure created the potential that residents would receive less than optimum benefit from prescribed medications. Findings include:</p> <p>1. Note: CMS Letter 13-02-NH, dated November 2, 2012, regarding the administration of Proton Pump Inhibitor (PPI) medications, stated on page 3, "For optimal therapeutic benefit, most PPIs should be administered on an empty stomach, ideally 30-60 minutes before meals. The rationale is that in order for the medication to provide the maximum benefit it needs to be present in the system before food activates the acid pumps so that the peak concentration of the PPI will coincide with maximal acid secretion. Some residents may report benefits of this medication being administered outside the 30-60 minutes prior to a meal and this needs to be determined and documented to justify the continued administration times."</p>	F 332	<p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Residents #1 and # 5 have been discharged from the facility.</p> <p>2. 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? All TCU residents have the potential to be affected.</p> <p style="text-align: right;">Continued</p>	8/14/13	

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F 332	<p>Continued From page 20</p> <p>On 07/9/13 at 9:15 a.m., LN #1 was observed giving 10 oral medications (including the PPI Nexium) and one subcutaneous injection to Resident #5.</p> <p>On 7/9/13 at 11:15 a.m., when asked when Resident #5 had breakfast that morning, LN #1 stated, "Breakfast was passed at 8:30." When asked about the administration of Nexium at 9:15 a.m., the LN stated, "Yeah, she had it after breakfast."</p> <p>The facility's procedure for "Medication Administration", effective 1/8/13, stated on page 4, "Before administering a medication, the individual authorized to administer medications will: ... B. Verify that the medication is being administered at the proper time..."</p> <p>The Nursing 2013 Drug Handbook on page 524, regarding the oral administration of Nexium, states in part, "Give drug at least 1 hour before meals."</p> <p>Resident #5 was administered Nexium after the breakfast meal rather than before the meal which resulted in a timing error.</p> <p>2. On 7/10/13 at 11:30 a.m., LN #4 was observed as he administered 12 oral medications, 1 topical patch, and a topical cream to Resident #1. The oral medications included magnesium oxide, citalopram, lactobacillus acidophilus, mesalamine, phosphorus, calcium carbonate, Magic Mouthwash, biphos/potassium, Lomotil, vitamin D, therapeutic vitamin, and Detrol LA.</p>	F 332	<p>3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? Resident #1's Rx, Nexium, was ordered bid. The administration time for this Rx was changed from 0800 to 0700 to ensure it was administered ac. The hospital pharmacist has changed the routine administration times for bid PPI Rxs to 0700 and 1500 to ensure they are administered before meals. LN#1 was educated on proper procedure to follow when a Rx is not available, which includes calling the pharmacy to send the Rx to the floor.</p> <p>This LN was also educated on the need to notify the attending physician if/when a Rx dose is omitted. Additionally, education was provided to all TCU nursing staff at the July 23<sup>rd</sup> and 25<sup>th</sup> staff meetings.</p> <p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The clinical pharmacist will continue to review all resident's medication regimen on a monthly (or more frequent) basis. The MDS Coordinator will contact a biweekly audit of at least 5 TCU residents. Results of these audits will be submitted to the DON for review on a biweekly basis with follow up corrective action as needed.</p>		

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F 332	Continued From page 21 That afternoon, reconciliation of the medications with Resident #1's physician's orders revealed an order, dated 5/28/13, for Mycostatin 5 ml before meals and bedtime. However, the Mycostatin was not administered during the 11:30 a.m. medication pass observation.  At 4:30 p.m., when asked about Resident #1's Mycostatin, LN #4 stated it was not administered because it was not available until after lunch.  The omitted medication resulted in a medication error.  On 7/11/13 at 2:25 p.m., the DON was informed of the medication errors. However, no other information or documentation was received from the facility that resolved the issue.	F 332			
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.  (b) Preventing Spread of Infection	F 441	Please see page 23		

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F 441	<p>Continued From page 22</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure residents' tuberculosis (TB) skin tests were completed on admission. This affected 2 of 9 (#s 1 &amp; 2) residents sampled for the TB skin test. This practice created the potential for harm should the residents be exposed to the bacteria that causes TB. Findings included:</p> <p>1. Resident #1 was admitted to the facility on 5/12/13 with multiple diagnoses including right humerus fracture.</p> <p>Review of the resident's medical record and electronic database medical record did not provide evidence the resident was administered</p>	F 441	<ol style="list-style-type: none"> <li>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Residents #1 and #2 have been discharged from the facility.</li> <li>2. 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? All TCU residents have the potential to be affected.</li> <li>3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? All residents admitted to TCU will have a TB skin test completed within 30 days of admission.</li> <li>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? All residents' LOS will be discussed at the weekly interdisciplinary team meeting. Those residents with a LOS of 21 days will be identified and a physician's order for a TB skin test will be obtained and administered prior to day 30 of their LOS.</li> </ol>	8/14/13	

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F 441	Continued From page 23 the TB skin test on admission or within 30 days of admission.  Federal guidance at F441 indicated, "...Tuberculosis screening on admission...consistent with State requirements..."  2. Resident #2 was admitted to the facility on 6/4/13 with multiple diagnoses including sepsis.  Review of the resident's medical record and electronic database medical record did not provide evidence the resident was administered the TB skin test on admission or within 30 days of admission.  On 7/10/13 at 3:40 p.m., the surveyor informed the DON of the TB skin test not completed for Resident #2. The DON stated, "We do not do the TB skin test unless ordered by the MD. When a resident stays beyond 30 days, we do a TB skin test."	F 441			
F 460 SS=D	483.70(d)(1)(iv)-(v) BEDROOMS ASSURE FULL VISUAL PRIVACY  Bedrooms must be designed or equipped to assure full visual privacy for each resident.  In facilities initially certified after March 31, 1992, except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains.  This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was	F 460	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #1 has been discharged from the facility.  2. 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? All TCU residents have the potential to be affected.  Continued	8/14/13	

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F 460	<p>Continued From page 24</p> <p>determined the facility failed to maintain resident's full visual privacy when broken blinds allowed anyone in the hallway to view inside the room. This was true for 1 of 7 (#5) sampled residents. This created the potential for a negative effect on the resident's self esteem. Findings include:</p> <p>On 7/10/13 at 10:05 AM, Resident #5's hallway door was closed. Next to the door were two windows, which each measured one and a half feet wide and three feet tall. Each contained privacy blinds operated from inside the room. The blind closest to the closed door contained two pieces of missing slats which were both six inches wide and one inch high. The surveyor was able to look into the room through either slat standing approximately a foot away from the window. When the surveyor looked through the window, he could see all of the resident's clothed body in her bed and a therapy assistant standing next to the bed. Most of the room was also visible through the broken slats, along with the ability to view directly into the resident's bathroom.</p> <p>On 7/11/13 at 10:40 AM, the DON and the surveyor were outside of the resident's window. The surveyor ask the DON to look through the missing blind slats and she stated, "Yeah, you can see her [Resident #5]." No other information was provided by the facility.</p>	F 460	<p>3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? The blinds in Resident #1's room were replaced on July 10, 2013.</p> <p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? During daily rounding done by charge nurses and weekly rounding done by leadership team, broken blinds will be monitored and a work order initiated for replacement if found. Results of these rounding audits will be reported to the DON on an ongoing basis.</p>		

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C 000	16.03.02 INITIAL COMMENTS  The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2. The following deficiencies were cited during the State licensure survey of your facility.  The surveyors conducting the survey were: Karen Marshall, MS, RD, LD Team Coordinator Bradley Perry, BSW, LSW Linda Kelly, RN  Survey definitions:  DON = Director of Nursing	C 000	<i>Revised state form 8/29/13 Dorothy Yelton RN/DON</i>	
C 125	02.100,03,c,ix Treated with Respect/Dignity  ix. Is treated with consideration, respect and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; This Rule is not met as evidenced by: Please refer to F164 as it related to providing residents privacy during cares.  Please refer to F241 as it related to dignity.	C 125	Please refer to F 164 and F241	8/14/13
C 519	02.121,06,a PATIENT/RESIDENT DINING & RECREATION  06. Patient/Resident Dining and Recreation Areas. The following minimum requirements apply to dining/recreation areas.	C 519		

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FACILITY STANDARDS

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*[Signature]*  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE  
**NHA**

(X6) DATE  
8/29/13

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C 519	Continued From page 1  a. Area requirement. The total area set aside for these purposes shall be at least thirty (30) square feet per bed with a minimum, total area of at least two hundred twenty-five (225) square feet. For facilities with more than one hundred (100) beds, the minimum area may be reduced to twenty five (25) square feet per bed. If day care programs are offered, additional space shall be provided as needed to accommodate for day care patients/residents needing naps or for dining and activities. This Rule is not met as evidenced by: Based on observation, review of a previous room size waiver, and staff interview, it was determined the facility did not ensure the TCU (Transitional Care Unit) dining/recreation room complied with state regulation, the dining room must contain 30 square feet per bed. This was true for 7 of 7 (#s 1-7) sampled residents and had the potential for residents to not participate in recreational activities or eat in the dining room should the dining/recreation room become too crowded. Findings include:  During the initial tour of the facility on 7/9/13 at 1:15 p.m., it was observed the dining/recreation room in the TCU did not meet the minimum requirements. Specifically, the area measured 443 square feet, instead of the required 480 square feet.  During the survey process, a total of three different residents were observed dining in the dining/recreation area.  On 7/11/13 at 2:25 p.m., The DON was asked if the facility would continue to request a waiver of	C 519	We are requesting a waiver of the Square footage requirement as set by The Bureau of Facility Standards for our facility's dining room. It is my understanding that according to these standards, our dining room is thirty-seven (37) square feet small than required. Upon recent observation by surveyors this was not found to compromise the residents' dining experience.	8/14/13

Bureau of Facility Standards

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C 519	Continued From page-2  the dining/recreation room size. The DON stated, "Yes, we want to request a waiver."  The surveyors found the decreased space did not compromise residents' dining/recreation experience. The request for a waiver renewal for this requirement should be included in the Plan of Correction.	C 519		
C 664	02.150,02,a Required Members of Committee  a. Include the facility medical director, administrator, pharmacist, dietary services supervisor, director of nursing services, housekeeping services representative, and maintenance services representative. This Rule is not met as evidenced by: Based on staff interview and review of the Infection Control Meeting Minutes, it was determined the facility failed to ensure the pharmacist, the Dietary Services Supervisor (DSS), a representative from the maintenance department, and a representative from the housekeeping department attended the Infection Control Meetings on a regular basis. This had the potential to affect all residents, staff and visitors in the facility. Findings included:  On 7/11/13, the facility's Infection Preventionist provided the Infection Control Committee Meeting Minutes and attendance logs for March and May 2013. Review of those 2 attendance logs revealed the following committee members did not attend the meetings as follows: * March - The DSS, a maintenance representative, and a housekeeping representative; * May - The pharmacist, the DSS, a housekeeping representative, and a maintenance	C 664	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? All residents interviewed during this survey have been discharged. 2. 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? All TCU residents, staff and visitors have the potential to be affected. 3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? The DON met with the Infection Control committee on July 24, 2013. Required attendees will be invited to all Infection Control meetings. A typed roster of the required attendees will be initiated; attendees will sign this roster verifying their attendance. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Attendance of the required personnel will be monitored by the infection Control Coordinator and reported to the DON on a quarterly basis with follow up with required attendees as needed.	8/14/13

## Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  MDS001180	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  07/11/2013
NAME OF PROVIDER OR SUPPLIER  EASTERN IDAHO REGIONAL MEDICAL CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE 3100 CHANNING WAY, 83404 IDAHO FALLS, ID 83403		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 664	Continued From page 3 representative.  On 7/11/13 at 2:25 p.m., the DON was informed of the issue. No other information or documentation was received from the facility that resolved the issue.	C 664		
C 667	02.150,02,d Annual Review of Policies/Procedures  d. Review policies and procedures as needed but no less often than annually. This Rule is not met as evidenced by: Based on policy and procedure (P&P) review and staff interview, it was determined the facility failed to ensure all infection control P&Ps were reviewed annually. This had the potential to affect all residents, staff and visitors to the facility. Findings include:  On 7/10/13 at about 4 p.m., when asked how often the infection control committee reviewed infection control policies, the Infection Preventionist (IP) stated the P&Ps were set for review every 3 years.  Examples of infection control policies that were not reviewed annually included: * Introduction to the Infection Control Program - effective date 4/2/10, next review date 4/9/16; * Hand Hygiene - effective date 4/6/10, next review date 4/9/16; * Standard Precautions - effective date 6/20/11, next review date 6/20/14; * Isolation Room Assignment - effective date 3/22/11, next review date 3/22/14; and, * Vancomycin Resistant Enterococcus (VRE) House-wide Protocol - effective date 10/5/10, next review date 3/25/15.	C 667	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? All residents interviewed during the survey have been discharged. 2. 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? All TCU residents, staff and visitors have the potential to be affected. 3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? The DON met with the Infection Control committee on July 24, 2013. The Infection Control Coordinator will review the Infection Control P&Ps on an annual basis. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The annual review of all Infection Control P&Ps will be monitored by the Infection Control Committee on bimonthly basis.	8/14/13

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C 667	Continued From page 4  On 7/11/13 at about 2:25 p.m., the DON was informed of the issue. No other information or documentation was received from the facility that resolved the issue.	C.667		
C 787	02.200,03,b,iii Fluid/Nutritional Intake  iii. Adequate fluid and nutritional intake, including provisions for self-help eating devices as needed; This Rule is not met as evidenced by: Please refer to F279 as it related to not updating a care plan with nutrition interventions.	C 787	Please refer to F279	8/14/13
C 788	02.200,03,b,iv Medications, Diet, Treatments as Ordered  iv. Delivery of medications, diet and treatments as ordered by the attending physician, dentist or nurse practitioner; This Rule is not met as evidenced by: Please refer to F328 as it related to: * not following physician's orders for administration of oxygen, * admission orders did not include oxygen, the resident received oxygen however a handwritten order did not specify a liter flow, and * Unclear oxygen orders for a resident and the orders did not specify a liter flow.  Please refer to F279 as it related to not care planning Ativan and Ambien for a resident.	C 788	Please refer to F328 and F279	8/14/13
C 811	02.200,04,g,vii Medication Errors Reported to Physician  vii. Medication errors (which shall	C 811	Please refer to F332	8/14/13

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C 811	Continued From page 5  be reported to the charge nurse and attending physician. This Rule is not met as evidenced by: Please refer to F332 as it related to medication errors.	C 811		
C 813	02.200,05,a Results of TB Skin Test  a. The results of a T.B. skin test shall be established for each patient/resident upon admission. If the status is not known upon admission, a T.B. skin test shall be done as soon as possible, but no longer than thirty (30) days after admission.  This Rule is not met as evidenced by: Please refer to F441 as it related to residents not screened for TB.	C 813	Please refer to F441	8/14/13
C 820	02.201,01,a 30-Day Review of All Meds  a. Reviewing the medication profile for each individual patient at least every thirty (30) days. The attending physician shall be advised of drug therapy duplication, incompatibilities or contraindications.  This Rule is not met as evidenced by: Please refer to F329 as it related to no clinical rationale for duplicate anti-depressant therapy.	C 820	Refer to F329	8/14/13
C 856	02.201,04,c Documentation of Use and Results  c. Reasons for administration of a PRN medication and the patient's/resident's response to the	C 856	Please refer to F329	8/14/13

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C 856	<p>Continued From page 6</p> <p>medication shall be documented in the nurse's notes.</p> <p>This Rule is not met as evidenced by: Please refer to F329 as it related to: * not monitoring as needed medications, Ativan and Ambien, and * no clinical rationale for duplicate anti-depressant therapy.</p>	C 856		