



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 2434

July 30, 2013

Stephen Farnsworth, Administrator
Pocatello Care & Rehabilitation Center
527 Memorial Drive
Pocatello, ID 83201

Provider #: 135011

Dear Mr. Farnsworth:

On **July 11, 2013**, we conducted an on-site follow-up revisit to verify that your facility had achieved and maintained compliance. We had presumed, based on your allegation of compliance, that your facility was in substantial compliance as of **June 7, 2013**. However, based on our on-site follow-up revisit conducted **July 11, 2013**, we found that your facility is not in substantial compliance with the following participation requirements:

F280 -- S/S: D -- 42 CFR §483.20(d)(3), 483.10(k)(2) -- Right to Participate Planning Care-Revise CP

F314 -- S/S: G -- 42 CFR §483.25(c) -- Treatment/Services to Prevent/Heal Pressure Sores

F514 -- S/S: D -- 42 CFR §483.75(l)(1) -- Resident Records-Complete/Accurate/Accessible

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. **Please provide ONLY ONE completion date for each federal and state tag in column X5 (Complete Date), to signify when you allege that each tag will be back in compliance.** After each deficiency has been answered and dated, the administrator should sign both Statement of Deficiencies and Plan of Correction, Form CMS-2567 and State Form, in the spaces provided and return the originals to this office.

Stephen Farnsworth, Administrator
July 30, 2013
Page 2 of 4

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **August 12, 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.

- The administrator must sign and date the first page of both the federal survey report, Form

Stephen Farnsworth, Administrator
July 30, 2013
Page 3 of 4

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*.

As noted in the letter of **May 9, 2013**, following the **Recertification, Complaint Investigation and State Licensure of April 26, 2013**, we made recommendation to the Centers for Medicare and Medicaid Services (CMS) for Denial of Payment for New Admissions and termination of the provider agreement on **October 26, 2013**, if substantial compliance is not achieved by that time.

On May 20, 2013, CMS sent you a letter outlining remedies that included Denial of Payment for New Admissions (DPNA) and an on-going Civil Money Penalty (CMP) of \$450.00 per day. We recommend continuation of these remedies.

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.

STATE ACTIONS effective with the date of this letter (**July 30, 2013**):

IDAPA 16.03.02.003.05.b.v.(b) states:

d. A major deficiency is defined as:

(b) Repeat violation of any requirement of these rules, regulation and minimum standards of Idaho law.

At this survey, the facility had one (1) repeat deficiency from the **Recertification, Complaint Investigation and State Licensure** survey of **April 26, 2013**.

C789 -- IDAPA 16.03.02.200.03.b.v. -- Prevention of Decubitus

If the facility is not found to have achieved substantial compliance at the time of the next survey, the Department of Health & Welfare, Bureau of Facility Standards will pursue a licensure action, up to and including revocation as determined appropriate.

If you believe the 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)

Stephen Farnsworth, Administrator
July 30, 2013
Page 4 of 4

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.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You may also contest scope and severity assessments for deficiencies, which resulted in a finding of SQC or immediate jeopardy. 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 12, 2013**. If your request for informal dispute resolution is received after **August 12, 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 on-site follow-up revisit. If you have any questions or concerns, please contact this office at (208) 334-6626.

Sincerely,



Lorene Kayser, L.S.W., Supervisor
Long Term Care

LKK/dmj
Enclosures

cc: Survey, Certification & Enforcement Branch, Western Division of Survey & Certification,
Seattle Regional Office

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

PRINTED: 07/30/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135011	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 07/11/2013
NAME OF PROVIDER OR SUPPLIER POCATELLO CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 527 MEMORIAL DRIVE POCATELLO, ID 83201		
(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}	INITIAL COMMENTS The following deficiencies were cited during an on-site follow up to a recertification and complaint investigation survey. The surveyors conducting the on-site follow-up survey were: Nina Sanderson, LSW, Team Coordinator Amy Jensen, RN F 280 483.20(d)(3), 483.10(k)(2) RIGHT TO SS=D PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review, and staff interview it could not be determined when specific interventions were implemented, revised, and/or	{F 000}			

RECEIVED
AUG 12 2013
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  TITLE **Executive Director** (X6) DATE **8/7/13**

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.

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

PRINTED: 07/30/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135011	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 07/11/2013
NAME OF PROVIDER OR SUPPLIER POCATELLO CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 527 MEMORIAL DRIVE POCATELLO, ID 83201		
(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 280	<p>Continued From page 1</p> <p>discontinued on a residents care plan. This was true for 1 of 1 sampled residents (# 20) and had the potential to result in harm if the resident did not receive appropriate care due to lack of direction on the care plan. Findings include:</p> <p>Resident #20 was admitted to the facility on 3/19/13, with multiple diagnoses including, closed fracture multiple cervical vertebrae, MRSA (Methicillin-resistant Staphylococcus Aureus), chronic pain syndrome, pressure ulcers, and anxiety.</p> <p>Resident #20's Care Plan documented the following:</p> <p>*Focus section initiated on 3/22/13, "Stage IV ulcer to buttocks with exposed fascia, bone, muscle, and femoral artery."</p> <p>*Intervention section (did not include date), "Provide tx (treatment) as ordered by MD and refer to TAR for changes."</p> <p>*Focus section initiated on 3/22/13, "Potential for additional skin and wound deterioration related to: no sensation to LEs (Lower Extremities)..."</p> <p>*Intervention section (did not include date), "Provide measures to decrease pressure/irritation to skin: Pressure relieving air mattress, heel protectors, pillows for positioning. Keep air mattress cover clean, dry, and free of wrinkles. Monitor that it has the correct setting. Provide with positioning every 2-3 hours and prn."</p> <p>*Focus section initiated on 3/29/13, "At risk for falls r/t (related to) unaware of safety needs, paralysis, and no sensation of legs."</p> <p>*Intervention section (did not include date), "Bed to be positioned away from wall and scoop mattress to be placed to bed."</p> <p>NOTE: The only dates documented on each of</p>	F 280			

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

PRINTED: 07/30/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135011	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 07/11/2013
NAME OF PROVIDER OR SUPPLIER POCATELLO CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 527 MEMORIAL DRIVE POCATELLO, ID 83201		
(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 280	<p>Continued From page 2</p> <p>the care plans were the "Initiated dates" which indicated the initial date the "Focus area"/problem was identified and the "Target Date" which indicated the date the identified goal should be met. It could not be determined when the Care Plan Focus Area and Intervention areas were reviewed or revised.</p> <p>On 7/09/13 at 3:20 p.m., Resident #20 was observed laying in his bed on a "scoop" mattress with his legs in a "butterfly" position. The lateral aspect of the resident's knees, legs, ankles, and feet were positioned directly on the mattress. The resident's heels were not, "floated," and they did not have heel protectors on. The only pillows observed in the resident's room were the pillows behind his head. Multiple dressings were visible on his lower extremities and feet.</p> <p>NOTE: The resident was suppose to have his heels floated, heel protectors on, air mattress to promote skin integrity/wound healing, and pillows for positioning. Refer to F 314 for additional information regarding the pressure ulcers.</p> <p>On 7/10/13 at 12:15 p.m., the DNS, Administrator, and Clinical Resource Consultant were informed and asked about the above Care Plan concerns. No further information was provided related to heel protectors, floated heels, or pillows for positioning. The Clinical Resource Consultant said the facility had decided to change to the scoop mattress to decrease the residents risk of falls and potentially rupturing his, "exposed femoral artery." The surveyor asked the facility how they determined the scoop mattress, used to prevent falls, for a resident that had paraplegia and the inability to move his lower extremities independently was the most appropriate</p>	F 280			

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

PRINTED: 07/30/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135011	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 07/11/2013
NAME OF PROVIDER OR SUPPLIER POCATELLO CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 527 MEMORIAL DRIVE POCATELLO, ID 83201		
(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 280 {F 314} SS=G	Continued From page 3 intervention and why the pressure relieving mattress to prevent further deterioration of his wound and potentially promote wound healing was not being used. No additional information or documentation was provided by the facility. 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 observation, policy review, staff and resident interview, and record review, it was determined the facility failed to provide the necessary care and services to prevent the development of new pressure sores and promote healing for existing pressure sores. This was true for 1 of 4 residents (Resident #20) sampled for pressure sores. The deficient practice resulted in harm for Resident #20 when: *Resident #20 did not receive dressing changes as ordered to a Stage IV pressure wound to his sacrum and buttocks. This wound increased in size and depth. *Resident #20 developed at least six stage three pressure sores that were not present upon admission. *The locations of Resident #20's pressure	F 280 {F 314}			

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

PRINTED: 07/30/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135011	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 07/11/2013
NAME OF PROVIDER OR SUPPLIER POCATELLO CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 527 MEMORIAL DRIVE POCATELLO, ID 83201		
(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 314}	Continued From page 4 wounds were not accurately monitored or documented. At least 11 of the 12 wounds that were identified between 6/11/13 and 7/1/13 were not consistently documented on from week to week. *Resident #20 was on a scoop mattress, instead of the pressure relieving air mattress specified in his care plan. *Wound documentation was not coordinated with hospice staff. *Heel protectors and pillows to prevent contact with the mattress were not provided per Resident #20's plan of care. Findings include: The facility's "Policy and Procedure - Clinical Best Practices" for Skin Monitoring and Management, Revised 5/2007, 9/2009, and 7/2010, documented, in part: -"It is understood that a resident may experience pain associated with the presence of a wound...Therefore, the nursing staff shall be responsible to assess the resident for complaints of pain...prior to treatment..." -"Once a wound has been identified, assessed, and documented, nursing shall administer treatment to each affected area...all wound or skin treatments should be documented in the resident's clinical record at the time they are administered..." -"...In order to...prevent existing pressure ulcers from worsening, nursing staff shall implement the following approaches...Stabilize, reduce, or remove any underlying risks. Monitor impact of interventions and modify interventions as appropriate...Use pressure relieving/reducing and redistributing devices (including but not limited to low air loss mattresses, wedges, pillows,	{F 314}			

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

PRINTED: 07/30/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135011	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 07/11/2013
NAME OF PROVIDER OR SUPPLIER POCATELLO CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 527 MEMORIAL DRIVE POCATELLO, ID 83201		
(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 314}	Continued From page 5 etc.)...obtain a physician order for appropriate pressure relieving/reducing devices..." -"Continue preventive measures as appropriate, including but not limited to: Pressure reduction...Re-evaluate existing treatment regimen in connection with the resident's clinical presentation, to include interventions and care plan considerations, if any wound is non-healing or not showing signs of improvement after 14 days or any time a wound is worsening..." -"Monitoring...daily via medication administration and treatment administration records. Ensure all orders have been implemented as ordered." Resident #20 was admitted to the facility on 3/19/13 with diagnoses which included paraplegia, Stage IV pressure ulcer to his sacrum, and chronic pain syndrome. Resident #20's most recent MDS, dated 6/20/13, coded: *BIMS of 8, indicating moderately impaired cognitive skills. *Extensive assistance of 2 or more persons required for bed mobility, dressing, and personal hygiene. *Total dependence on two or more persons for toileting *Did not transfer, ambulate, or otherwise move about the unit. *No rejection of care. *Impaired range of motion in both lower extremities. *Unhealed pressure ulcers present, at risk of developing further ulcers. *Six Stage III pressure ulcers present, none had been present at the time of admission to the facility. *One Stage IV pressure ulcer present, which had	{F 314}			

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

PRINTED: 07/30/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135011	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 07/11/2013
NAME OF PROVIDER OR SUPPLIER POCATELLO CARE & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 527 MEMORIAL DRIVE POCATELLO, ID 83201		
(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 314}	<p>Continued From page 6</p> <p>been present at the time of admission. *Stage IV pressure ulcer measured 25 centimeters (cm) long, 31 cm wide, 8 cm deep. *Six Stage III pressure ulcers [PU] and two Stage IV pressure ulcers which were not present or were present at a lesser stage on the prior assessment. *Pressure reducing devices for chair and bed, nutrition and hydration interventions, and pressure ulcer care in place for treatment. *No pain in the 5 days prior to the assessment. *Two or more falls without injury since the time of admission.</p> <p>Resident #20's care plan documented: -Focus of, "Has a terminal prognosis r/t multiple chronic decubitus ulcers", initiated 3/22/13. Approaches of, "Assess resident coping strategies and respect resident wishes", and, "Work with nursing staff to provide maximum comfort for the resident." -Focus of, "Potential for severing femoral artery r/t being exposed due to open wound on buttock." Initiated 6/25/13. Interventions of, "FYI - there are dark towels in the cabinet above the closet in case the artery breaks," and, "Is is [sic] recommended that he be bed rest only. Provide with repositioning every 2-4 hours and prn for comfort." -Focus of, "Stage IV ulcer to buttocks with exposed fascia, bone, muscle, and femoral artery. Has drainage and foul odor caused by prolonged exposure related to: incontinence, lack of sensation, cognitive impairment, non-adherence with therapeutic regime, chronic non-healing wound and MRSA in wound. Expected decline in wound and placed for Hospice care." Initiated 3/22/13. Interventions of, "Communicate with Hospice nurse on when</p>	{F 314}		

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

PRINTED: 07/30/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135011	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 07/11/2013
NAME OF PROVIDER OR SUPPLIER POCATELLO CARE & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 527 MEMORIAL DRIVE POCATELLO, ID 83201		
(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 314}	<p>Continued From page 7</p> <p>dressing changes are to be performed and by whom, " "Medicate for pain as needed prior to dressing changes. FYI: due to decrease sensation to lower body he has not expressed pain during wound changes but still has potential for pain," and, "Provide tx [treatment] as ordered by MD and refer to TAR for changes."</p> <p>-Focus of, "Potential additional skin and wound deterioration related to:\no sensation to LEs [lower extremities] \hospice diagnosis." Initiated 3/22/13. Interventions of, "Provide measures to decrease pressure/irritation to skin: Pressure relieving Air mattress, heel protectors, pillows for positioning", and "Keep air mattress cover clean, dry, and free of wrinkles. Monitor that it has the correct setting."</p> <p>- "At risk for falls r/t Unaware of safety needs, paralysis, and no sensation of legs." Initiated 3/29/13. Interventions of, "bed to be in low position away from wall and scoop mattress to be placed to bed."</p> <p>NOTE: While Resident #20's care plan contained initiation dates for the Focus areas, there were no dates to determine when each intervention was added or revised. Please see F280 as it pertains to care plan revisions and F514 as it relates to accuracy of records.</p> <p>Physician's Progress Notes documented: -5/31/13, "...receiving palliative care with hospice due to massive sacral/gluteal tissue destruction from non-healing ulcers...Pt [patient] has episodes of pain and delirium...wound care is only palliative trying to keep clean, dry, clear of infection and odor...arranged wound change schedule, hospice in AM, facility in PM." -6/28/13, "...massive non-healing sacral ulcer...will continue to do best given these limited options..."</p>	{F 314}		

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

PRINTED: 07/30/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135011	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 07/11/2013	
NAME OF PROVIDER OR SUPPLIER POCATELLO CARE & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 527 MEMORIAL DRIVE POCATELLO, ID 83201		
(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 314}	<p>Continued From page 8</p> <p>Resident #20's All Active Orders for June 2013 form (Recaps) documented: -"SN [Skilled Nurse] at facility to change dressing on buttock and sacral area. -NOCS [night shift] Everyday, 1830-0630 [between 6:30 PM and 6:30 AM]." Order date was documented as 6/13/13.</p> <p>Resident #20's Treatment Administration Record (TAR) for June 2013 documented, "SN at facility to change dressing on buttock and sacral area. Order Date 6/13/13. NOCS [night shift] every day." The TAR was blank for 6/13/13, 6/14/13, and 6/15/13, with the first facility dressing change documented on 6/16/13.</p> <p>On 6/7/13, a facility Skin Assessment for Resident #20 documented, "Pt [patient] has several open areas. Please reference Treatment record. Pt is being treated by hospice and wound care for open areas."</p> <p>On 6/19/13, a Braden Scale for Predicting Pressure Sore Risk for Resident #20 coded, "12", indicating the resident has at High Risk for pressure ulcers.</p> <p>Resident #20's Nurse's Progress Notes documented: -6/13/13 at 2:38 AM, "Drsg to coccyx changed..." NOTE: From an anatomical perspective, the coccyx, sacrum, and buttocks are different parts of the body. -6/14/13 and 6/15/13, no dressing changes documented. -No refusals of care 6/14/13 - 6/17/13 -Air mattress in place on 6/14/13, but a scoop mattress on 6/19/13, with no explanation as to when or why the change was made.</p>	{F 314}		

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

PRINTED: 07/30/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135011	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 07/11/2013
NAME OF PROVIDER OR SUPPLIER POCATELLO CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 527 MEMORIAL DRIVE POCATELLO, ID 83201		
(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 314}	<p>Continued From page 9</p> <p>-6/24/13 at 2:10 AM, "Changed Pt's Dressing to buttocks. Wound being changed by hospice nurse during the daytime. Pt wound was bleeding more today than last weeks dressing changes. Pt was given 1 mg Morphine prior to dressing change to help decrease pain." NOTE: The facility did not document evening dressing changes to Resident #20's sacrum and buttocks per MD order on 6/13/13, 6/14/13, or 6/15/13.</p> <p>-6/28/13 at 1:23 AM, "During dressing change resident began screaming and became agitated believing we were 'packing' the wound bed. [RN #8] wound nurse with me at the time and tried to calm resident and reassure but he remained agitated. Has been screaming most of the evening about things like getting water, plugging in speakers, etc. Calling staff in about every 5 to 10 minutes. When this nurse asked him to consolidate some items into a single trip he again began to scream and use multiple expletives. He continues to scream to this time. This nurse informed him he could have his door open and not scream or closed and scream. He told this F... that." NOTE: There was no documentation Resident #20 was assessed for pain before or during this dressing change.</p> <p>7/4/13 at 7:00 AM, "Pt slept well through the night, he had no complaints of pain. Pt dressing to coccyx area was changed at 0015 (12:15 AM) on 7/4/13..."</p> <p>-7/7/13 at 6:08 PM, "Dressing to buttocks changed. two person assist. Rt. [Resident] expressed discomfort during the procedure. Wound bed red, moist...some exudate present on old dressings, plus bm [bowel movement]..."</p> <p>-7/8/13 at 11:50 PM, "Pt had complaints of moderate pain this evening. Pt was given PRN</p>	{F 314}			

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

PRINTED: 07/30/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135011	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 07/11/2013
NAME OF PROVIDER OR SUPPLIER POCATELLO CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 527 MEMORIAL DRIVE POCATELLO, ID 83201		
(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 314}	<p>Continued From page 10</p> <p>morphine with effectiveness. Pt dressing was changed at 2330 [11:30 PM]." NOTE: This entry did not specify which of Resident #20's dressings was changed.</p> <p>"Skin Pressure Ulcer Weekly" (SPUW) forms: NOTE: The facility's SPUW forms displayed a diagram of a human body with various parts of the body numbered 1-52. The form prompted the user to identify each wound location with a corresponding number on the body diagram. Each week, Resident #20 was noted with a total of between 6 and 8 PUs. Facility documentation of the location of the PUs was inconsistent from week to week, with some, but not all, wounds being assigned a number for identification. Additionally, some, but not all, wounds were documented weekly. Resident #20's SPUWs documented 12 different descriptions of his pressure ulcers. For the purpose of ease of reading this citation, the surveyor has numbered the pressure ulcers as wounds #s 1 - 12:</p> <p>In addition, per SPUW forms and staff interview, the hospice nurses for Resident #20 were assessing and measuring his wounds, then provided that information to RN #8, who then documented that information into Resident #20's record. Please see interviews below.</p> <p>SPUW's documented the following between 6/11/13 and 7/1/13:</p> <p>a. Regarding Pressure Ulcer #1:</p> <p>-6/11/13: Description documented as, "Bilateral Buttocks and sacrum stage IV pressure ulcer with exposed bone, fascia, muscle, tendons, and arteries." Size: 24.0 cm X 29.0 cm X 7 cm. The</p>	{F 314}			

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

PRINTED: 07/30/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135011	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 07/11/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER POCATELLO CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 527 MEMORIAL DRIVE POCATELLO, ID 83201
---	--

(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 314}	<p>Continued From page 11</p> <p>wound was documented as having large amounts of serosanguinous exudate with a foul odor. The wound bed was described as "Pink/Beefy Red." Surrounding skin color was documented as "Normal for Skin" with "Peripheral Tissue Edema." Resident #20 was described as having no pain. The "Additional Documentation" area of the form documented, "...The dressing is changed twice daily. Hospice staff changes dressing every am [morning] and facility nursing staff changes dressing [at] HS [bedtime] daily..."</p> <p>-6/17/13: Description as, "Bilateral buttocks and sacrum stage 4 pressure site present on admit." Size: 25 cm X 32 cm X 8 CM. "Exudate type" was documented as, "Serosanguinous." "Exudate Amount" was documented as, "Copious." The odor was documented as, "Foul." The Wound Bed was, "Black/Brown (Eschar)." The surrounding skin color was, "White/Gray Pallor." The Surrounding tissue/wound edges was documented as, "Peripheral tissue edema." Additional documentation was, "Dressing is changed Q am [every morning] by hospice staff and Q pm [every evening] by facility staff..."</p> <p>NOTE: Between 6/11/13 and 6/17/13, Resident #20's wound to his buttocks and sacrum had grown in size and depth. The facility did not have documentation the dressing had been changed per MD order on 6/13/13, 6/14/13, or 6/15/13. The amount of exudate had increased from "large" to "copious." The wound bed had deteriorated from "pink/beefy red" to "black/brown eschar." Skin color surrounding the wound had deteriorated from, "normal for skin" to "white/gray pallor." Nevertheless, two days after this assessment of Resident #20's wound, the facility documented Resident #20 as being on a "scoop" mattress, rather than the air mattress he had</p>	{F 314}		
---------	--	---------	--	--

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

PRINTED: 07/30/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135011	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 07/11/2013
NAME OF PROVIDER OR SUPPLIER POCATELLO CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 527 MEMORIAL DRIVE POCATELLO, ID 83201		
(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 314}	<p>Continued From page 12 previously been documented as using.</p> <p>6/26/13: Description as, "23, 54, 55, 53 (referring to numbers on the human body diagram on the form) coccyx, left buttock, sacrum stage IV pressure ulcer present upon admit." Size: 22 cm X 27 cm X 8 cm. Exudate type as, "serosanguinous", exudate amount as, "large." Odor was documented as, "foul." Wound bed was documented as, "slough." Surrounding skin color was documented as, "White/Gray Pallor." Surrounding Tissue/Wound Edges as, "Peripheral Tissue Edema." "Additional Documentation" included, "...Dressing is changed BID [twice per day], AM per hospice nurse, PM per facility nurse...No reports or indications of pain or discomfort."</p> <p>NOTE: Between 6/17/13 and 6/26/13, the wound became smaller in length and width. Nurse's Progress Notes indicated Resident #20 was on a scoop mattress, rather than a pressure-relieving air mattress.</p> <p>7/1/13 - Site as, "53) Sacrum." Description as, "Sacral/bilateral buttocks stage IV PU site... Size: 22 cm X 34 cm X 8 cm. The "Additional Documentation" area of the form stated, "...Changed BID and PRN. NOTE: These measurements of Wound #1 indicated the wound had grown in size during this week. During this time, facility documentation indicates Resident #20 was on a scoop mattress, rather than a pressure-relieving air mattress.</p> <p>NOTE: There was no documentation the facility had implemented interventions for this Stage IV pressure ulcer as defined in their policy and specified in Resident #20's care plan. There was no documentation the facility had re-evaluated the</p>	{F 314}			

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

PRINTED: 07/30/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135011	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 07/11/2013	
NAME OF PROVIDER OR SUPPLIER POCATELLO CARE & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 527 MEMORIAL DRIVE POCATELLO, ID 83201		
(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 314}	<p>Continued From page 13</p> <p>existing treatments for Resident #20's Stage IV pressure ulcer even though it had not shown improvement, and in fact had shown signs of deterioration, between 6/11/13 and 7/1/13. The facility could not provide documentation that wound treatments were documented in Resident #20's clinical record at the time they occurred.</p> <p>b. Regarding the rest of the Pressure Ulcers.</p> <p>-Wound #2. 6/11/13, site documented as, "45) Right ankle (inner)." Description as, "Right medial ankle stage III pressure site." Size: 2 cm X 2 cm X 1 cm.</p> <p>-Wound #3. 6/11/13, site as, "Other (specify)." Description as, "Right medial foot Stage III pressure ulcer." Size: 3.5 cm X 3 cm X 1 cm.</p> <p>-Wound #4. 6/11/13, site as, "Other (specify)." Description as, "Right lateral distal lower leg previously two Stage III pressure sites are now one Stage III pressure site." Size: 2.5 cm X 2.0 cm X 1.0 cm.</p> <p>NOTE: There was no further documentation for wounds 2, 3, or 4, and no explanation as to whether or not they had healed.</p> <p>-Wound #5. Site documented as, "49) Right heel." Description as, "Right posterior heel Stage III pressure ulcer." Documented on 6/11/13, 6/17/13, and 6/26/13, with improvement noted each week. Not documented on 7/1/13, with no explanation as to what had happened with that wound.</p> <p>-Wound #6. 6/11/13, site as, "42) Left lower leg (front)." Description as, "Left lateral distal lower</p>	{F 314}		

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

PRINTED: 07/30/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135011	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 07/11/2013
NAME OF PROVIDER OR SUPPLIER POCATELLO CARE & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 527 MEMORIAL DRIVE POCATELLO, ID 83201		
(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 314}	<p>Continued From page 14</p> <p>leg stage III pressure ulcer." Size: 4 cm X 3 cm X 1 cm.</p> <p>NOTE: There was no further documentation on this wound, and no explanation as to whether or not it had healed.</p> <p>-Wound #7. Site as, "37) Right knee (front)." Description as, "Right lateral knee stage III pressure ulcer site." 6/11/13, size: 1.5 cm X 2 cm X 1 cm. 6/17/13, size: 2 cm X 2 cm X 0.5 cm. NOTE: Wound #7 was longer, but not as deep on 6/17/13 as it was on 6/11/13. There was no further documentation on this wound, and no explanation as to whether or not it had healed.</p> <p>-Wound #8. Site as, "Other." Description as, "Right medial mid dorsum stage II pressure site." 6/17/13, size 3 cm X 2 cm X 0.5 cm. Documented again on 6/26/13 with slight improvement in size.</p> <p>-Wound #9. 6/17/13, site as, "41) Right lower leg front." Description as, "Right distal anteriolateral leg stage II pressure ulcer." Size as, "3 cm X 2 cm X 0.5 cm." NOTE: Wounds #8 and #9 did not directly correspond to any wound documented during the week of 6/11/13. See interviews below regarding facility explanation for assessing and measuring wounds.</p> <p>-Wound #10. Site as, "50) left heel." Description as, "Left heel stage II pressure site." 6/17/13, size 3 cm X 3 cm X 0.5 cm. 6/26/13, size 3 cm X 5 cm X 0.5 cm. NOTE: These measurements documented the wound increased in size between 6/17/13 and 6/26/13. This wound was not documented on 6/11/13. See interviews below.</p>	{F 314}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135011	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 07/11/2013
NAME OF PROVIDER OR SUPPLIER POCATELLO CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 527 MEMORIAL DRIVE POCATELLO, ID 83201		
(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 314}	<p>Continued From page 15</p> <p>-Wound #11. 6/26/13, site as, "43) Right lower leg (rear)." Description as, "Right posteriolateral distal leg stage II." Size: 2 cm X 2 cm X 0.5 cm. NOTE: Wound #11 was not noted on 6/11/13 or 6/17/13,</p> <p>-Wound #12. 6/26/13, site as, "44) Left lower leg (rear)." Description as, "Left posteriolateral lower leg stage II pressure site." Size: 3 cm X 2 cm X 0.75 cm. NOTE: Wound #12 was not noted on 6/11/13 or 6/17/13.</p> <p>There was also a single SPUW for 7/1/13, which listed Wound #1, "all stage II PU's" to Resident #20's right posteriolateral leg, as well as PUs to Resident #20's right heel, left heel, right medial mid dorsum, left lateral distal leg, and right anteriolateral patellar. NOTE: Many of these wounds were not staged. The documentation is unclear as to whether or not these were the same wounds the facility had been monitoring or if they were new wounds. There was also no documentation stating whether some of the wounds being monitored by the facility had improved or resolved since the previous week's assessment.</p> <p>On 7/9/13 at 3:20 PM, the surveyor observed Resident #20 in his room. He was lying in bed, on his back and buttocks, with the head of his bed elevated approximately 30-45 degrees. He was lying in a "scoop" mattress, with built-up edges of the mattress approximately 6 inches in height, on both sides of the head and foot of the bed. There was a sheet on the mattress, but the sheet was askew, having come loose from the edges of the mattress. The sheet had bunched up underneath Resident #20 with several large wrinkles under him where he laid. There was a pillow behind his</p>	{F 314}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135011	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 07/11/2013
NAME OF PROVIDER OR SUPPLIER POCATELLO CARE & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 527 MEMORIAL DRIVE POCATELLO, ID 83201		
(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 314}	<p>Continued From page 16</p> <p>head, but no other pillows were visible. He was wearing a T-shirt and gym-type shorts, with his legs and feet exposed. His feet were bare. His legs were in a "butterfly" position, with the weight of his legs resting on the outer aspects of his knees, calves, ankles, and feet. His knees, calves, ankles, and feet were positioned directly on the wrinkles in the sheet or the bare mattress. There were multiple skin tears and dressings visible on both of his legs. He was not wearing any kind of heel protection, nor were his heels or ankles being floated. Resident #20 welcomed the surveyor into his room. His mother was sitting in a chair at bedside. The bed was high enough from the floor that the mattress was even with Resident #20's mother's neck and upper chest as she sat in the chair, rather than the low position specified in Resident #20's care plan.</p> <p>On 7/9/13 at 4:45 PM, RN #8, identified as the facility wound nurse, was asked about Resident #20's pressure ulcers. RN #8 stated Resident #20's wounds were assessed and measured by hospice, then hospice reported those findings to RN #8, who then entered the information into Resident #20's record in the facility. RN #8 stated she did not actually assess or measure the wounds herself before entering the data into Resident #20's medical record, but rather relied on the information received from hospice. RN# 8 stated the wound to Resident #20's buttocks and sacrum received daily dressing changes from hospice, and "as needed" dressing changes from the facility. RN #8 stated if Resident #20 needed a dressing change other than the ones provided by hospice, she would come in to the facility and do it herself, even if it meant she had to come in on a weekend, evening, or holiday.</p>	{F 314}		

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

PRINTED: 07/30/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135011	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 07/11/2013
NAME OF PROVIDER OR SUPPLIER POCATELLO CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 527 MEMORIAL DRIVE POCATELLO, ID 83201		
(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 314}	<p>Continued From page 17</p> <p>On 7/10/13 at 8:20 AM, the two surveyors reviewed Resident #20's TAR for July 2013 with the DNS, ADON, and administrator. The area of the TAR to document the facility nurse had changed Resident #20's dressing to his buttocks and sacrum every evening, was blank except for July 1, 2013. The DNS stated because Resident #20 was a "special case" as far as his wounds, the dressing changes for his sacral wounds had been placed on the Medication Administration Record (MAR) instead of the TAR for this resident. However, the DNS reported, "We can't find the MAR for this wound. We have looked everywhere and will keep looking, but we can't find it anywhere," and "I'm going to go look in the shred box next." The DNS was then asked about the weekly SPUW forms for Resident #20, and the lack of consistency in the documentation of Resident #20's wounds. In particular, the pressure ulcer to Resident #20's left heel which was not documented on 6/11/13, but was documented on 6/17/13. The DNS stated the wound to Resident #20's left heel had "always been there", but was not correctly or consistently documented by the hospice nurse. The Administrator then stated the facility had had a meeting with hospice so they "could all get on the same page." The Administrator stated he could not recall the date of that meeting, and the facility did not make notes of the content of that meeting or the plan moving forward after the meeting occurred.</p> <p>NOTE: Resident #20's hospice record indicated the meeting took place on 6/21/13, two weeks after the facility alleged compliance for F314.</p> <p>On 7/10/13 at 8:40 AM, the surveyors, along with RN #4, looked at Resident #20's July 2013 MAR. There was no area on the MAR to document</p>	{F 314}			

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

PRINTED: 07/30/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135011	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 07/11/2013
NAME OF PROVIDER OR SUPPLIER POCATELLO CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 527 MEMORIAL DRIVE POCATELLO, ID 83201		
(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 314}	<p>Continued From page 18</p> <p>dressing changes to Resident #20's sacral and buttock wound. RN #4 stated, "It's not there now. It was there, at the front, on a page by itself." RN #4 stated she did not do the dressing changes for Resident #20, because she worked day shift, but she did get a report from the nurses who did the dressing changes.</p> <p>On 7/10/13 at 9:45 AM, the surveyors again met with the Administrator, DNS, and the corporate Clinical Resource person (CR). The DNS was asked about the blank areas on Resident #20's June 2013 TAR (6/13/13-6/15/13) for the evening dressing changes to his sacrum and buttocks. The DNS stated, "We missed it. That's why we decided to put it on the MAR." The DNS was then asked about the documentation for the dressing change to that wound beginning 7/2/13. The DNS stated, "It was documented in the nurse's notes." The surveyor and the DNS reviewed Resident #20's nurse's notes together, and found narrative documentation of dressing changes on 7/4/13 to the "coccyx area", 7/7/13 to the "buttocks", and 7/8/13 "dressing change" with no location specified. The DNS was then asked to describe the process for wound dressing changes for Resident #20. The DNS stated Resident #20 had been on hospice since prior to his admission, and hospice had been treating Resident #20's buttocks wound for, "A long time. So for consistency, we let them keep doing it." The DNS was asked if the facility had any responsibility for assessing, measuring, or changing the dressings for any of Resident #20's wounds. The DNS stated, "No. Hospice does that." [NOTE: Resident #20 had a physician's order for the facility to begin providing routine dressing changes to the wound on his sacrum and buttocks, beginning 6/13/13.] The DNS and Administrator were asked</p>	{F 314}			

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

PRINTED: 07/30/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135011	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 07/11/2013
NAME OF PROVIDER OR SUPPLIER POCATELLO CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 527 MEMORIAL DRIVE POCATELLO, ID 83201		
(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 314}	<p>Continued From page 19</p> <p>again about the inconsistencies with the wound documentation for Resident #20's wounds. The Administrator stated, "We've had several meetings with them [hospice] to discuss it [inconsistency in wound documentation.]" The administrator stated he did not recall when the meetings were. The surveyor then informed the Administrator of the documentation in Resident #20's hospice record indicating the meeting took place on 6/21/13, which was after the facility's alleged compliance date. The Administrator stated, "But we met with them before, too." The Administrator, DNS, and CR were informed of the surveyor's concerns of continued non-compliance at F 314. The CR stated, "I understand."</p> <p>On 7/10/13 at 10:15 AM, the surveyors observed a dressing change for Resident #20's buttocks and sacral wound. The dressing change was performed by the hospice nurse, with RN #8 and a hospice CNA present to assist. Upon entering Resident #20's room, he was observed again to be in bed with his legs in a "butterfly" position, with a pillow behind his head, with bare feet and legs. He was on the same type of scoop mattress as observed the day before. No heel protectors were in place, his heels were not floated, and there were no pillows being used for positioning besides the pillow behind his head. The hospice nurse asked Resident #20 if she could take his vital signs before beginning. Resident #20 declined. With the hospice nurse and CNA on Resident #20's left, and RN #8 on his right, the three rolled him onto his right side to begin the dressing change. They did not tell Resident #20 they were going to roll him over. As they rolled him over, the surveyor noted a bed sheet, a draw sheet, an incontinence pad, and an incontinence brief were all between Resident #1 and the</p>	{F 314}			

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

PRINTED: 07/30/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135011	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 07/11/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER POCATELLO CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 527 MEMORIAL DRIVE POCATELLO, ID 83201
---	--

(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 314}	Continued From page 20 mattress. Upon exposing the wound to Resident #20's buttocks, the surveyor asked if this wound was considered Wound #1 for this resident. The hospice RN stated, "It was Wound #1 and #2, then it merged as one wound. I'm not sure if we're calling it Wound 1 or Wound 2 now." The surveyor observed a large wound encompassing the entirety of Resident #20's buttocks. It was only when Resident #20 began to have a bowel movement that the surveyor was able to discern the location of Resident #20's anus. The inner portion of the wound was red and dry with a dark area inside his left buttock wound. Using her gloved hand, the hospice nurse inserted her hand into Resident #20's wound and began to press on the darkened area. The hospice nurse identified this area as a "bladder fistula." There was an odor of stale urine and sweat in the room prior to the dressing change, with the added odor of stool when Resident #20 began to have a bowel movement. Scant serous drainage was noted on the soiled dressing removed from the wound. As the hospice nurse began to clean the wound, the wound began to bleed. There was an exposed softball-sized mass located on the lateral side of his right hip area. The hospice nurse stated she had measured the wound the day before, and was not prepared to measure the wound again at this time. As Resident #20 was laying on his right side, supported by RN #1 and the hospice CNA, he began to call out, "Ow. Sh** [expletive]. My shoulder. It hurts." RN #8 stated, "We'll be done soon." No further assessment was made of Resident #20's discomfort and no correction was offered (pain meds, repositioning, etc) to correct his discomfort. The surveyor asked about the type of mattress being used for Resident #20. The hospice nurse identified it as a, "scoop mattress because we don't want him to fall." The	{F 314}		
---------	---	---------	--	--

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

PRINTED: 07/30/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135011	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 07/11/2013
NAME OF PROVIDER OR SUPPLIER POCATELLO CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 527 MEMORIAL DRIVE POCATELLO, ID 83201		
(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 314}	<p>Continued From page 21</p> <p>surveyor asked if an air mattress had been considered for Resident #20. At that time, Resident #20 stated, "It's uncomfortable", referring to the bed. Resident #20 stated, "The only reason I have this one (sore) on my hip is because of this mattress." At that point, the blanket covering the upper portion of Resident #20's body slipped off to the side of his body (the blanket remained on the bed). Resident #20 stated, "What are you doing?" RN #8 then picked up the corner of the blanket and tossed it over Resident #20, so that the blanket was covering Resident #20's chest, as well as his head. RN #8 then looked at the surveyor and stated, "He likes to hide." Meanwhile, Resident #20 was using his arms and attempting to twist his torso so as to remove the blanket from his head. The hospice CNA then began to use a wipe to clean Resident #20's stomach and chest. She did not tell Resident #20 she was going to clean him. Resident #20 became upset and stated, "Don't clean me up with that. Use a warm washcloth." The CNA then went to the bathroom to get a warm washcloth to use to clean Resident #20.</p> <p>On 7/10/13 at 12:30 PM, the ADON, and RN #8 were asked about Resident #20's care plan, which called for an air mattress for his wounds. RN #8 stated, "No. He has a scoop mattress." RN #8 was asked why, with such a substantial wound to his buttocks and sacrum, as well as at least 6 other pressure ulcers, Resident #20 would not have an air mattress, RN #8, who was identified as the facility wound nurse, stated, "I'm not sure." RN #8 was asked who in the facility made the determination as to which mattress should be used for Resident #20. RN #8 stated, "The MDS nurse and the interdisciplinary team." RN #8 was asked if she had input on this process as the</p>	{F 314}			

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

PRINTED: 07/30/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135011	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 07/11/2013
NAME OF PROVIDER OR SUPPLIER POCATELLO CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 527 MEMORIAL DRIVE POCATELLO, ID 83201		
(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 314}	Continued From page 22 facility wound nurse. RN #8 stated, "No. I just do the dressing changes." On 7/10/13 at 12:35 PM, the Administrator, ADON, and the corporate CR person were again interviewed by the surveyors. RN #15 was also present. The corporate CR person handed the surveyor a yellow paper which was consistent in appearance with the facility's MAR documents. Resident #20's name was in the lower right hand corner of the document and the date on the form was documented as, "July 2013". The document had an area for, "Cleanse buttocks wound with wound wash, pat dry, pack with ABD pads, place carbon pad in wound bed, cover with ABD pads and tape in place. Order Date: 6/13/13. NOCS every day." This form contained spaces for a time and nurse's initials to be documented every day. These spaces were filled out for 7/1/13 through 7/9/13. Aside from this dressing change, there was no indication of anything else to be documented on that form. The corporate CR person stated the facility could not locate the page from Resident #20's July 2013 MAR which documented the evening dressing changes to his sacral and buttocks wounds. The corporate CR person stated, "We had [the ADON] drive all over town, to the homes of the nurses who changed those dressings, and we re-created the MAR. We are not representing this as the original, but we have re-created the MAR." The corporate CR person identified RN #15 as one of the nurses who would have been responsible to change Resident #20's dressing to his sacrum and buttocks. RN #15 stated he had worked on the evening shift for 7/2/13 and 7/6/13, and would have changed Resident #20's dressings on those shifts and documented it on the MAR. RN #15 was uncertain as to where this document from	{F 314}			

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

PRINTED: 07/30/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135011	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 07/11/2013
NAME OF PROVIDER OR SUPPLIER POCATELLO CARE & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 527 MEMORIAL DRIVE POCATELLO, ID 83201		
(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 314}	<p>Continued From page 23</p> <p>Resident #20's MAR had gone, but stated he recalled a page at the front of Resident #20's MAR with only the dressing change to Resident #20's sacral/buttocks wound on it.</p> <p>On 7/10/13 at 3:45 PM, The Administrator, DNS, and corporate CR person met again with the survey team. The surveyors asked if the facility had further information as to why Resident #20 did not have preventive/protective skin measures in place per his care plan, i.e., air mattress, heel protectors, positioning with pillows. The Administrator stated the facility had opted for the scoop mattress as Resident #20 had fallen out of bed twice right after his admission to the facility in March 2013. The surveyor asked if the facility had considered fall prevention measures which would also address Resident #20's skin needs. The Administrator stated the facility wanted to protect Resident #20 from potential injuries from a fall. The surveyors then asked if the facility had re-evaluated this plan in light of the severity and deterioration of Resident #20's wounds, and the development of at least 6 new pressure ulcers since admission. The corporate CR person stated they felt the potential for injury from a fall outweighed the need for an air mattress to treat Resident #20's wounds. The Administrator then stated, "Are you implying the wounds would heal if we did that stuff? Because the doctor has said they won't heal. No matter what we did, they would have gotten worse."</p> <p>On 7/10/13 at 4:51 PM, the Administrator, DNS, and corporate resource person presented the surveyors with a document, that stated, in part, "The documentation [of the dressing change for Resident #20's sacral and buttocks wounds] was present on 7/9/13 in the MAR and was noted to</p>	{F 314}		

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

PRINTED: 07/30/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135011	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 07/11/2013
NAME OF PROVIDER OR SUPPLIER POCATELLO CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 527 MEMORIAL DRIVE POCATELLO, ID 83201		
(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 314}	<p>Continued From page 24</p> <p>be missing on 7/10/13. [NOTE: At the time plan was presented, the dressing change for 7/10/13 was not yet due. The DNS had indicated throughout the day on 7/10/13 the MAR for Resident #20's dressing change was missing, and the corporate CR person indicated the facility had re-created the MAR.] Each nurse that worked on the dates in question verified that the dressing changes were completed per physician's order and have signed a MAR that has been recreated to show that the needed care was provided. [NOTE: The facility was unable to describe how a document which was "missing" could be "recreated" accurately.]"</p> <p>On 7/15/13 at 8:00 AM, the surveyor discovered a photocopied document from the facility, similar in appearance to a facility MAR or TAR form, dated July 2013, for Resident #20. The document contained times and initials of facility staff, indicating Resident #20 had received a dressing change to his sacral/buttocks wound daily from 7/1/13 - 7/9/13, between midnight and 4:00 AM. In addition, this form also contained areas to document wound dressing changes to Resident #20's bilateral lower extremities. NOTE: The times of the dressing changes on this document were identical to the times which were on the form the facility "re-created."</p> <p>On 7/13/13 at 8:50 AM, the surveyor called the facility and spoke to the DNS. The DNS confirmed, twice, that the documentation of the dressing change was not present after 7/1/13, when the DNS and surveyor looked at Resident #20's TAR, and that there was no page found in Resident #20's MAR with dressing change documentation, as of 7/10/13. The surveyor then asked about the photocopied document indicating</p>	{F 314}			

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

PRINTED: 07/30/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135011	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 07/11/2013
NAME OF PROVIDER OR SUPPLIER POCATELLO CARE & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 527 MEMORIAL DRIVE POCATELLO, ID 83201		
(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 314}	<p>Continued From page 25</p> <p>the dressing changes had been done. The DNS stated, "I'm not sure. Fax it to me and I'll look into it."</p> <p>On 7/13/13 at 11:00 AM, the surveyor received a telephone call from the Administrator and the DNS. The Administrator stated, "Well, we looked into it, and this is the original documentation from [Resident #20's] MAR that we couldn't find while you were here." The surveyor asked where the facility had located the document. The Administrator stated, "It was in a stack of documents in medical records." The surveyor asked why the facility did not provide this information to the surveyor when it was requested. The DNS stated, "We didn't know it was in our possession. We didn't look in medical records. We didn't know about it until you called this morning." The DNS was asked why an active document from Resident #20's current MAR or TAR would be pulled and placed in the medical records department. The DNS stated, "I don't know." The DNS again confirmed that when she and the surveyor looked at the TAR for Resident #20, the dressing change documentation from 7/2/13 to 7/9/13 was blank. The DNS also confirmed the facility was unable to locate a page from Resident #20's MAR while surveyors were on site showing the dressing change had been completed. The surveyor asked how, and why, if the facility was not aware of this document, how they were able to "re-create" it for the surveyors. The Administrator stated, "Yes, but now we have the original."</p> <p>Resident #20 was harmed as a result of the facility's deficient practice, when: (1) The Stage IV PU on his sacrum and buttocks did not receive dressing changes per MD order, grew in size and</p>	{F 314}		

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

PRINTED: 07/30/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135011	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 07/11/2013
NAME OF PROVIDER OR SUPPLIER POCATELLO CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 527 MEMORIAL DRIVE POCATELLO, ID 83201		
(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 314}	Continued From page 26 depth with increased drainage and deterioration in the nature of the wound bed and surrounding tissue; (2) The resident developed at least six Stage III PU; (3) The facility relied on hospice staff to assess and measure Resident #20's wounds. Even so, they did not have consistent accurate documentation of the locations of Resident #20's wounds; (4) Resident #20 did not have devices in place per facility policy and per his plan of care to prevent, as much as possible, his wounds from worsening (i.e., pressure relieving air mattress, pillows, heel protectors, bed coverings free from wrinkles); (5) Resident #4 stated he had ongoing discomfort from his scoop mattress, and was observed to have un-addressed discomfort during a dressing change on 7/10/13. NOTE: This is a repeat deficiency for the recertification survey of 4/26/13. The facility had alleged compliance with F 314 as of 6/7/13.	{F 314}			
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE 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. 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.	F 514			

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

PRINTED: 07/30/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135011	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 07/11/2013
NAME OF PROVIDER OR SUPPLIER POCATELLO CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 527 MEMORIAL DRIVE POCATELLO, ID 83201		
(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 514	<p>Continued From page 27</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to provide documentation in a resident's medical record that a resident received a dressing change two times a day as ordered by the physician. In addition the facility failed to ensure the care plan accurately reflected dates that reflected initiation or discontinuation of interventions. This impacted 1 of 1 residents sampled (#20) for wound care. Findings included:</p> <p>Resident #20 was admitted to the facility on 3/19/13, with multiple diagnoses including, close fracture multiple cervical vertebrae, MRSA ((Methicillin-resistant Staphylococcus Aureus), chronic pain syndrome, pressure ulcers, and anxiety.</p> <p>a) On 7/10/13 at 7:00 a.m., Resident #20's July 2013 Treatment Administration Record (TAR) was reviewed to verify twice daily dressing changes were being completed on the resident's buttocks to a Stage IV pressure ulcer. The TAR included initials and a triangle (indicating the dressing had been changed in the a.m.) by the Hospice nurse on 7/1/13 through 7/9/13. The TAR for the p.m. dressing changes to be done by the facility staff did not contain initials or a triangle, just the letter, "X."</p> <p>NOTE: It could not be determined what the letter "X" indicated related to the p.m. dressing changes being done. In addition, the TAR did not indicate the dressing changes for the Stage IV pressure ulcer on the residents buttocks would be documented on another form.</p>	F 514			

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

PRINTED: 07/30/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135011	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 07/11/2013
NAME OF PROVIDER OR SUPPLIER POCATELLO CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 527 MEMORIAL DRIVE POCATELLO, ID 83201	
(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 514	<p>Continued From page 28</p> <p>On 7/10/13 at 8:10 a.m. the DNS and Administrator were asked why Resident #20's TAR for 7/1/13 through 7/10/13 did not contain documentation related to the dressing changes being performed by the facility in the p.m.'s as directed by the Care Plan. The DNS said the p.m. dressing change performed by the facility was on the MAR (Medication Administration Record) to ensure it was being done. The DNS said the p.m. dressing change was moved from the TAR to the MAR because on 6/13/13, 6/14/13, and 6/15/13 the p.m. dressing change had not been done.</p> <p>- 8:15 a.m. the surveyors asked the DNS and Administrator to produce the MAR.</p> <p>- 9:45 a.m., the DNS and Administrator informed the surveyor's they had looked, "everywhere" for the MAR including medical records and could not find it. The DNS stated, "I am going to go look in the shred box to see if it got put in there."</p> <p>-12:35 p.m., the Administrator, ADON, and the Clinical Resource consultant provided, "a recreated MAR for the month of July 2013." The Clinical Resource consultant said, "We sent the ADON to the homes of the nurses that would have done the dressing changes and had the ADON obtain their initials on the recreated MAR." The Clinical Resource consultant said, "We are not representing this document as the original." In addition, the facility called LN #17 to attest to changing the dressings on the p.m. shift for 7/2/13 and 7/6/13.</p> <p>Refer to F314 for additional information related to the lack of consistency related to documentation of Resident #20's pressure ulcers.</p> <p>b) Resident #20's Care Plan documented the following:</p>	F 514		

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

PRINTED: 07/30/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135011	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 07/11/2013
NAME OF PROVIDER OR SUPPLIER POCATELLO CARE & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 527 MEMORIAL DRIVE POCATELLO, ID 83201		
(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 514	<p>Continued From page 29</p> <p>*Focus section initiated on 3/22/13, "Stage IV ulcer to buttocks with exposed fascia, bone, muscle, and femoral artery." *Intervention section (did not include date), "Provide tx (treatment) as ordered by MD and refer to TAR for changes." *Focus section initiated on 3/22/13, "Potential for additional skin and wound deterioration related to: no sensation to LEs (Lower Extremities)..." *Intervention section (did not include date), "Provide measures to decrease pressure/irritation to skin: Pressure relieving air mattress, heel protectors, pillows for positioning. Keep air mattress cover clean, dry, and free of wrinkles. Monitor that it has the correct setting. Provide with positioning every 2-3 hours and prn." *Focus section initiated on 3/29/13, "At risk for falls r/t (related to) unaware of safety needs, paralysis, and no sensation of legs." *Intervention section (did not include date), "Bed to be positioned away from wall and scoop mattress to be placed to bed."</p> <p>NOTE: The only dates documented on each area of the care plans were the "Initiated dates" which indicated the initial date the "Focus area"/problem was identified and the "Target Date" which indicated the date the identified goal should be met. It could not be determined when the Care Plan Focus Area and Intervention areas were reviewed or revised.</p>	F 514		

RECEIVED
SEP 06 2013
FACILITY STANDARDS

7/31/13

F 280

1. For resident #20 the care plan was reviewed and revised to reflect current skin interventions. All interventions will be dated as to initial implementation date and date resolved as appropriate. Note: in the electronic record, all focused areas, goals, and interventions include initiation dates which are visible by clicking on the "H (history button)" button next to each entry. Resident #20 has discharged on 8/20/2013.
2. Other residents with skin issues have the potential to be affected. All residents identified as high risk for pressure ulcer development or have pressure ulcers present will have care plans reviewed and updated as necessary.
3. The wound committee, which consists of a Wound Certified Physician, Director of Nursing (RN), Assistant Director of Nursing (RN), RN Wound/Treatment Specialist, Registered Dietitian, MDS Coordinator (RN) and Lead Certified Nursing Assistant will review and revise all skin goals and interventions for accuracy and implementation weekly. Note: no residents with skin issues under review are currently receiving hospice services, however in the future should residents requiring hospice services, hospice staff will be invited to attend.
4. Wound committee, including Wound Physician will meet weekly to review changes in physician orders, wound status and care plans. Skin Committee will audit skin/PU care plans weekly x 4 weeks, then every 2 weeks x 4, then monthly ongoing. Audits to begin 9/9/2013.
5. Date of compliance 8/12/2013

RECEIVED
SEP 16 2013
FACILITY STANDARDS

F 314

1. For resident #20 facility placed air mattress per MD order, care plan was updated to include instructions to straighten bed linens, ensure placement of heel protectors and facility to perform weekly and PRN wound measurements. Resident #20 was seen by wound specialist to include head to toe skin assessment. Pain management was addressed to include pain assessment before, during and after dressing changes. Wound Specialist (RN) will assess and document on all wounds weekly.
2. All residents with skin issues were evaluated for the need to be seen by a wound specialist. Any emerging skin issues will be evaluated by the skin committee weekly. Residents assessed at high risk on the Braden Scale will be identified and assessed weekly by the RN Wound Specialist and or designee (Licensed Staff). All current interventions will be reviewed for effectiveness and additional interventions put in place if necessary. Skin committee (including Wound Physician) will determine the effectiveness of the interventions for patients with skin issues.
3. The wound committee, which now includes a newly hired wound specialist will review and revise all skin goals and interventions for accuracy and implementation.
4. Wound committee, including Wound Physician will meet weekly to review changes in physician orders, wound status documentation and care plans. Skin Committee will audit skin/PU, TARs and care plans weekly x 4 weeks, then every 2 weeks x 4, then monthly ongoing. Audits to begin 9/9/2013. Reported to QA monthly.
5. Date of compliance 8/12/2013.

RECEIVED

SEP 16 2013

F 514

FACILITY STANDARDS

1. Original TAR for resident #20 was located and placed in TAR binder which included the completed treatments from July 2 through July 11.
2. All residents with treatments and interventions for skin have had TAR reviews to ensure accuracy.
3. Accuracy of documentation for skin issues will be verified by the wound committee, weekly.
4. DNS or RN designee to audit TARs daily for completion daily x 2 weeks, then 3x/week x 4 weeks, then weekly x 1 month. Audits to start 8/5/2013.
5. Date of compliance 8/12/2013.

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001020	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 07/11/2013
--	--	---	--

NAME OF PROVIDER OR SUPPLIER POCATELLO CARE & REHABILITATION CENTE	STREET ADDRESS, CITY, STATE, ZIP CODE 527 MEMORIAL DRIVE POCATELLO, ID 83201
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{C 000}	<p>16.03.02 INITIAL COMMENTS</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 an on-site follow up to a recertification and complaint investigation survey. The surveyors conducting the on-site follow-up survey were:</p> <p>Nina Sanderson, LSW, Team Coordinator Amy Jensen, RN</p>	{C 000}		
C 782	<p>02.200,03,a,iv Reviewed and Revised</p> <p>iv. Reviewed and revised as needed to reflect the current needs of patients/residents and current goals to be accomplished; This Rule is not met as evidenced by: Please refer to F280 as it relates to periodic review and revision of care plans.</p>	C 782		
{C 789}	<p>02.200,03,b,v Prevention of Decubitus</p> <p>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 as it relates to pressure ulcers.</p>	{C 789}	<p>RECEIVED</p> <p>AUG 12 2013</p> <p>FACILITY STANDARDS</p>	
C 881	<p>02.203,02 INDIVIDUAL MEDICAL RECORD</p> <p>02. Individual Medical Record. An</p>	C 881		

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



TITLE
Executive Director

(X6) DATE
8/7/13

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001020	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 07/11/2013
--	--	---	---

NAME OF PROVIDER OR SUPPLIER POCATELLO CARE & REHABILITATION CENTE	STREET ADDRESS, CITY, STATE, ZIP CODE 527 MEMORIAL DRIVE POCATELLO, ID 83201
--	--

(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 881	Continued From page 1 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 F514 as it relates to the maintenance of a complete medical record.	C 881		
-------	---	-------	--	--

C 782

1. For resident #20 the care plan was reviewed and revised to reflect current skin interventions. All interventions will be dated as to initial implementation date and date resolved as appropriate. Note: in the electronic record, all focused areas, goals, and interventions include initiation dates which are visible by clicking on the "H (history button)" button next to each entry. Resident #20 has discharged on 8/20/2013.
2. Other residents with skin issues have the potential to be affected. All residents identified as high risk for pressure ulcer development or have pressure ulcers present will have care plans reviewed and updated as necessary.
3. The wound committee, which consists of a Wound Certified Physician, Director of Nursing (RN), Assistant Director of Nursing (RN), RN Wound/Treatment Specialist, Registered Dietitian, MDS Coordinator (RN) and Lead Certified Nursing Assistant will review and revise all skin goals and interventions for accuracy and implementation weekly. Note: no residents with skin issues under review are currently receiving hospice services, however in the future should residents requiring hospice services, hospice staff will be invited to attend.
4. Wound committee, including Wound Physician will meet weekly to review changes in physician orders, wound status and care plans. Skin Committee will audit skin/PU care plans weekly x 4 weeks, then every 2 weeks x 4, then monthly ongoing. Audits to begin 9/9/2013.
5. Date of compliance 8/12/2013

RECEIVED
SEP 16 2013
FACILITY STANDARDS

1. For resident #20 facility placed air mattress per MD order, care plan was updated to include instructions to straighten bed linens, ensure placement of heel protectors and facility to perform weekly and PRN wound measurements. Resident #20 was seen by wound specialist to include head to toe skin assessment. Pain management was addressed to include pain assessment before, during and after dressing changes. Wound Specialist (RN) will assess and document on all wounds weekly.
2. All residents with skin issues were evaluated for the need to be seen by a wound specialist. Any emerging skin issues will be evaluated by the skin committee weekly. Residents assessed at high risk on the Braden Scale will be identified and assessed weekly by the RN Wound Specialist and or designee (Licensed Staff). All current interventions will be reviewed for effectiveness and additional interventions put in place if necessary. Skin committee (including Wound Physician) will determine the effectiveness of the interventions for patients with skin issues.
3. The wound committee, which now includes a newly hired wound specialist will review and revise all skin goals and interventions for accuracy and implementation.
4. Wound committee, including Wound Physician will meet weekly to review changes in physician orders, wound status documentation and care plans. Skin Committee will audit skin/PU, TARs and care plans weekly x 4 weeks, then every 2 weeks x 4, then monthly ongoing. Audits to begin 9/9/2013. Reported to QA monthly.
5. Date of compliance 8/12/2013.

RECEIVED
SEP 16 2013
FACILITY STANDARDS

C 881

1. Original TAR for resident #20 was located and placed in TAR binder which included the completed treatments from July 2 through July 11.
2. All residents with treatments and interventions for skin have had TAR reviews to ensure accuracy.
3. Accuracy of documentation for skin issues will be verified by the wound committee, weekly.
4. DNS or RN designee to audit TARs daily for completion daily x 2 weeks, then 3x/week x 4 weeks, then weekly x 1 month. Audits to start 8/5/2013.
5. Date of compliance 8/12/2013.

RECEIVED
SEP 16 2013
FACILITY STANDARDS