



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 1499

August 26, 2014

Steve Gannon, Administrator
Safe Haven Care Center of Pocatello
1200 Hospital Way
Pocatello, ID 83201-2708

Provider #: 135071

Dear Mr. Gannon:

On **August 12, 2014**, a Complaint Investigation survey was conducted at Safe Haven Care Center of Pocatello by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be an isolated deficiency that constitutes actual harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

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

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **September 8, 2014**. Failure to submit an acceptable PoC by **September 8, 2014**, may result in the imposition of civil monetary penalties by **September 29, 2014**.

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

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

Steve Gannon, Administrator
August 26, 2014
Page 3 of 4

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 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*.

This agency is required to notify CMS Region X of the results of this survey. We are recommending that CMS impose the following remedy:

Denial of payment for new admissions effective as soon as notice requirements can be met. [42 CFR §488.417(a)]

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **February 12, 2015**, if substantial compliance is not achieved by that time.

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

If you believe these deficiencies have been corrected, you may contact Lorene Kayser, L.S.W., Q.M.R.P. or David Scott, R.N., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, Fax #: (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. 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>

Steve Gannon, Administrator
August 26, 2014
Page 4 of 4

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 **September 8, 2014**. If your request for informal dispute resolution is received after **September 8, 2014**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, comments or concerns, please contact Lorene Kayser, L.S.W., Q.M.R.P. or David Scott, R.N., Supervisors, Long Term Care at (208) 334-6626.

Sincerely,



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

LKK/dmj
Enclosures

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

PRINTED: 08/26/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/12/2014
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO	STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY 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 a complaint investigation at your facility. The surveyors conducting the survey were: Rebecca Thomas, RN, Team Coordinator Amy Barkley, RN, BSN,	F 000	Preparation and /or execution of this Plan of Correction (PoC) is not an admission of guilt nor does the provider agree with the conclusions set forth in the Statement of Deficiencies rendered by the Bureau. The Plan of Correction is prepared and executed simply as a requirement of federal and state law. We maintain that the alleged deficiencies do not individually, or collectively, jeopardize the health and safety of our residents, nor are they of such character as to limit this provider's capacity to render adequate resident care. Furthermore, the provider asserts that it is in substantial compliance with regulations governing the operation and licensure of skilled nursing facilities, and this document, in its entirety, constitutes this providers claim of compliance. Completion dates are provided for the procedural procession purposes to comply with the state and federal regulations, and correlate with the most recent contemplated or accomplished corrective action. These dates do not necessarily correspond chronologically to the date the provider is under the opinion it was in compliance with the requirements of participation or that corrective actions was necessary.	9/15/14
-------	--	-------	--	---------

F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in	F 157	It is Safe Haven's policy to notify families when there is a need to alter treatment. Notice of Medicare Non-Coverage for skilled services are to be sent out according to regulations at all times.	
---------------	---	-------	--	--

RECEIVED
OCT 01 2014
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
---	-------	-----------

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.

Gelder B. Moore Administrator 09/08/14
FORM CMS-2567 (02-99) Previous Versions Obsolete Event ID: 6DHP11 Facility ID: MDS001620 If continuation sheet Page 1 of 30

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

PRINTED: 08/26/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/12/2014
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY 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 157	<p>Continued From page 1</p> <p>injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility did not ensure a resident received the necessary notification of Medicare Non-Coverage before skilled nursing services ended. This was true for 1 of 4 (# 4) sampled residents. This had the potential to create harm should a resident, or their responsible party, experience emotional and financial distress when the necessary information was not provided in a timely manner. Findings</p>	F 157	<p>1. Resident #4 did not receive a notice in a timely manner. There was not a proper system in place for managing notification. There was a breakdown in communication between the therapy department and the billing officer regarding the amount of covered days the resident had available. The facility did not charge the resident and/or family for the days that were not covered.</p> <p>All residents receiving therapy in the facility had the potential to be affected.</p> <p>Safe haven has implemented a new system that will effectively track and monitor covered days of service and provide a clear line of communication to assure ABNs are sent out in a timely manner. A billing officer and the Rehab coordinator will attend the Daily stand-up meeting Monday-Friday and discuss the Medicare A/B and Medicaid caseload in detail, specifically regarding plan of treatment and continued treatment. The billing officer will also pull a weekly report on each resident's dates of stay. The billing officer will be responsible for sending out ABNs from this date forward.</p> <p>The Administrator/or designee will monitor the meetings to ensure compliance on a weekly basis for (12) weeks. The start date of these audits will be 09/01/2014.</p>	9/15/14

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

PRINTED: 08/26/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/12/2014
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO	STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY 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 157	Continued From page 2 Included: 1. Resident #4 was admitted to the facility on 12/23/13 with diagnoses of multiple trauma and therapy (physical, occupational) fracture of vertebral column dorsal closed, fracture of ribs closed - 2 ribs, and pain.	F 157		9/15/14
	Record review documented a Notice of Medicare Non-Coverage for skilled nursing services with an effective date of 3/8/14 was sent to the resident's family. The second page of the Notice was not signed but contained a handwritten statement by the resident's son-in-law, who is listed as the resident's personal contact, which documented, "This document was received at our address on 3/31/14, way past the required notification date as required by Health & Welfare guidelines." A typed letter, dated 4/3/14, was attached to the Notice which documented the family of Resident #4 had been told at least two different times by the facility that medicare coverage would end about April 2 or 3. The letter documented, "It is not our fault that you had miscalculated the remaining days of medicare A coverage. In checking with Health and Welfare, they indicated that you were required to provide this letter to us in anticipation of our mother being dropped from cover [sic], not that you notify us three weeks after she had already been dropped from coverage." On 8/12/14 at 9:35 AM, the surveyor interviewed the LSW who stated there was a Family Care Conference on 3/27/14. At that time, the family was made aware Resident #4's medicare was dwindling and the family thought the resident was strong enough to go to an assisted living facility. She stated this was the first discussion of the resident being discharged to another facility.			

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

PRINTED: 08/26/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/12/2014
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY 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 157	Continued From page 3 On 8/12/14 at 11:12 AM, the surveyor interviewed the LSW about the Notice of Medicare Non-Coverage, dated 3/8/14, in relation to the family's statement on 4/3/14, in which they had "been told as late as last week at least two different times from your staff that our medicare coverage would end about April 2 or 3rd." The LSW stated, "We thought her last day of billing would be 3/19/14 but we discovered it was actually 3/8/14." She then referenced the second page of the Notice of Medicare Non-Coverage where the family had written they would not be paying since the facility miscalculated the termination of coverage. When asked if the facility received payment, the LSW stated she would check into it. On 8/12/14 at 1:05 PM, the LSW stated to the surveyor, "I was able to find the facility forgave the amount and the family was not charged." On 8/12/14 at 6:25 PM, the Administrator and DNS were made aware of the facility's failure to notify the resident's family of medicare non-coverage before skilled nursing services ended. No further information was provided.	F 157		9/15/14
F 325 SS=G	483.25(I) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a	F 325		

F325
It is Safe Haven's policy to maintain acceptable parameters of nutritional status and proper therapeutic diets for all residents.

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

PRINTED: 08/26/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/12/2014
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY 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 325	<p>Continued From page 4 nutritional problem.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to identify weight loss trends and failed to implement interventions in a timely manner after the resident's weight loss became significant. This failed practice harmed 1 of 4 residents (#3) sampled for weight loss. The resident was harmed when he experienced severe weight loss of 18% and had a decrease in his ADL status. Additionally, this failed practice had the potential to harm any resident who experienced a compromised nutritional status. Findings included:</p> <p>Resident #3 was admitted to the facility on 1/22/14 with diagnoses of dementia with behavioral disturbance, depression, atrial fibrillation and depression.</p> <p>The resident's Admission MDS Assessment, dated 2/2/14, coded the resident's cognition was severely impaired and coded the resident's ADL's as follows: *was independent in bed mobility, transferring and walking in her room; *needed supervision with walking in the hall, on and off the unit and with dressing; *needed limited assistance of one person for eating; and, *71 inches tall and weighed 189 pounds.</p> <p>The resident's Significant Change MDS</p>	F 325	<p>Resident #3 was transferred to another facility on 5/2/2014.</p> <p>All residents have the potential to be affected.</p> <p>The meal monitoring system has been placed on the MAR, so that nurses are now looking at each meal to make certain residents are receiving adequate intake. This includes meal percentages, snacks, supplements, and substitutions.</p> <p>The NAR meeting has been changed and now is meeting based on the needs of the residents identified to be at risk. The NAR team consists of the DNS, the CDM, the Clinical Care Coordinator, The Skin/Wound Care Specialist, The secretary, and the RD on Wednesdays. This team is meeting three times per week.</p> <p>Weights are being obtained based on identified risk and loss. Weights are obtained as frequently as daily; to help identify the need for earlier intervention All residents are weighed weekly. Any resident with a 3% or greater weight loss in one week will be moved to a 3x/week weight, additional weight loss will move the resident to a daily weight. When daily weights are needed, the physician is being notified of those daily weights and the outcomes by the nurse Nursing Administration is making certain that the physician is responding to the notification and that response is charted. Interventions are being determined by the team as a whole, including nursing, dietary, pharmacy and the physician. When Nutrition Alerts are sent, the CDM notifies nursing that the Alert is being sent. Options have been added to the bottom of the Alert for the physician's response. Nursing assures follow up within 48 hours and signs off on the form. Before filing in the resident's record.</p>	9/15/14

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

PRINTED: 08/26/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/12/2014
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY 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 325	<p>Continued From page 5</p> <p>Assessment, dated 4/23/14, coded the resident was severely impaired and coded the resident's ADL's as follows:</p> <ul style="list-style-type: none"> *was independent in bed mobility; *needed supervision with transfers; *needed extensive assistance of 2+ persons when walking in the room, hall, on and off the unit, dressing, and eating; and, *71 inches tall and weighed 166 pounds. <p>Record review documented the resident's admission Physician's Orders, dated 1/22/14, as follows:</p> <ul style="list-style-type: none"> * Ativan 0.5 mg PO [by mouth] BID [twice daily] - PRN [as needed] - for anxiety. * Ativan 0.5 mg PO BID - for anxiety. - Adverse reactions include sedation, agitation, unsteadiness, dizziness, disorientation, and change in appetite. * Celexa 10 mg PO daily - for depression. - Adverse reactions include somnolence, anxiety, agitation, anorexia, and decreased or increased weight. * Aricept 5 mg PO daily - for dementia. - Adverse reactions include dizziness, somnolence, anorexia, weight loss, and urinary frequency. * Seroquel 25 mg PO BID - psychosis. - Adverse reactions include somnolence and anorexia. * Namenda 10 mg PO BID - dementia. - Adverse reactions include aggressiveness, agitation, confusion, dizziness, somnolence, anorexia, weight loss, urinary frequency, incontinence, and UTI (Urinary Tract Infection). <p>NOTE: The potential adverse reactions associated with the medications listed above are identified as such in the Nursing 2015 Drug</p>	F 325	<p>The Director of Nursing is co-chairing this meeting with the CDM and the RD is attending the meeting every Wednesday to give recommendations for dietary changes. Root cause analysis is being used to determine why a resident is losing weight. A Nutrition at Risk Review and Progress Note, plus a Summary sheet is completed on each resident reviewed in the NAR meeting. The Nutrition at Risk Review and Progress Note are filed in the resident record as a part of the permanent record.</p> <p>Pharmacy is being asked to evaluate medication usage and the relationship it has in weight loss, when medications are identified that could have potential risk, recommendations are made to the physician by the pharmacist.</p> <p>In-service:</p> <p>All nurses were in-serviced on the importance of documenting and communicating the intake of all residents. They were instructed on the documentation of meals, snacks, substitutes, and supplements on the MAR by nursing management.</p> <p>The CDM in-serviced the weight CNA on the weight program and the calibration of the scales. The same CNA does all the weights, she weighs the residents at approximately the same time of day, on the same scale, using the same equipment, and in approximately the same type of clothing.</p>	9/15/14

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

PRINTED: 08/26/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/12/2014
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY 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 325	<p>Continued From page 6</p> <p>Handbook. The medications that caused a change in appetite or anorexia included: Ativan, Celexa, Aricept, Seroquel and Namenda. Please refer to F-329 as it relates to medication use and pharmacy reviews.</p> <p>The resident's Nutritional-Risk Care Plan, with a start date of 2/3/14, documented a goal to "1. Maintain wt [weight] between 185-195 pounds." This goal was crossed out on 3/21/14 and a weight of "170-180" was added by the CDM. This second goal was crossed out by the CDM on 4/14/14 and replaced with "Have no c/o [complaints of] unmet hunger or thirst."</p> <p>Review of Weight Flow Sheets documented the resident experienced severe weight loss during the resident's 106 day admission at the facility. The Weight Flow Sheet documented an admission weight of 193 pounds on 1/22/14. The last recorded weight of 158.2 pounds was documented on 5/2/14. The resident was transferred to another facility on 5/8/14. The resident experienced a 34.8 pound weight loss (18%) during his admission. Guidance at F-325 documents that a greater than 10% weight loss in a 180 day period is considered severe. Additionally, the Weight Flow Sheet documented the resident lost 17 pounds (9%) in one week. On 3/6/14 the resident weighed 187.8 pounds and one week later, on 3/13/14, the resident weighed 170 pounds.</p> <p>On 2/5/14, a Comprehensive Nutritional Assessment by the CDM, documented in the Evaluation & Summary section, "No significant wt [weight] variance. Receiving a regular diet...Res[ident] is on meds that has the potential for anorexia." The Recommendation & Plan</p>	F 325	<p>Monitoring:</p> <p>The CDM will monitor the calibration of the scale every 2 weeks X3 months and monthly thereafter. This monitoring started on 09/05/2014. Nursing Management will monitor the MARs for completion and accuracy of meal percentages and supplement documentation on a weekly basis.</p> <p>The CDM will monitor the weight sheets weekly for weight loss of 3% or greater. This monitoring started on 08/20/2014.</p>	9/15/14

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

PRINTED: 08/26/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/12/2014
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO	STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY 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)	(X6) COMPLETION DATE
F 325	<p>Continued From page 7 section by the RD documented, "Continue POC. If wt, PO [per oral] decreases will adjust diet prn [as needed]."</p> <p>On 2/7/14 an order to DC (discontinue) the evening dose of Ativan 0.5 mg, an anxiolytic (anti-anxiety), was documented.</p> <p>On 2/28/14 an order to increase Seroquel, an antipsychotic medication, from 25mg BID to 50 mg BID was documented.</p> <p>On 3/14/14, a Nutritional Progress Note by the CDM documented, "Resident] wt down 16.2 pounds x 1 week. PO intake are B[reakfast] 50%, L[unch] 29% & D[inner] 66% and fluid intake is 222 ml average the past 7 days. Will Inform MD of wt loss and will put on Nutrition At Risk."</p> <p>On 3/21/14, a Nutrition Alert Sheet signed by the CDM, documented the resident lost 16.2 pounds in one week and the following interventions were started: "Informed nursing of wt loss and added to Nutrition At Risk (NAR)." There was documentation, "The resident is consuming an average of 48 % meals and 222 mL (milliliters) average per meal over the last 7 days." The bottom of the page contained a section for physician comments/orders, which was blank except for the physician's signature. Additionally, the physician's signature was not dated to indicate when the physician learned of the resident's weight loss, nor did the physician write an order or comment on the resident's 16.2 pound weight loss in one week.</p> <p>NOTE: The Nutritional Progress Note, dated 3/14/14, documented the resident would be put on NAR, however, the Nutrition Alert Sheet was</p>	F 325		9/15/14

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

PRINTED: 08/26/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/12/2014
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY 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 325	<p>Continued From page 8 not filled out until the next week on 3/21/14.</p> <p>On 3/26/14, a Nutritional Risk Review, documented the resident had a 30 day weight loss of 9.6 pounds and was added to the NAR related to weight loss. The Team Conclusion & Intervention section documented, "Added res[ident] to NAR r/t [related to] wt loss. Sent a nutr[ition] alert to MD on 3/14. Encourage fluid in between meals and meals [sic]. Add Fortified Diet." The Nutrition Related Meds section documented, "Refer to Nutr[ition] Assess[ment] 2/5/14."</p> <p>NOTE: The Weight Flow Sheet documented on 2/27/14 the resident weighed 187.8 pounds and on 3/27 the resident weighed 169.4 pounds, which would equal a 18.4 pound weight loss, not 9.6 pounds as stated in the above Nutritional Risk Review.</p> <p>A Quarterly Progress Note, dated 3/31/14, signed by a PA (Physician Assistant) on 4/1/14 and by the resident's physician on 4/7/14, documented, "Nurses state he has been stable. They have had no new concerns." The Assessment documented the following: "1) Atrial fibrillation, rate controlled. 2) Hypertension controlled. 3) Hyperlipidemia on therapy. 4) GERD on therapy. 5) Dementia, likely vascular, controlled." The Plan documented, "No changes made at this time."</p> <p>No documentation was found by the physician or the PA which addressed the resident's weight loss.</p>	F 325		9/15/14

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

PRINTED: 08/26/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/12/2014
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY 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 325	<p>Continued From page 9</p> <p>On 4/2/14, a Nutritional Progress Note by the CDM, documented, "Added snack TID [three times daily] between meals." Record review did not show an order for the 4/2/14 snack TID.</p> <p>On 4/4/14 an order to discontinue the evening dose of Ativan 0.5 mg was documented.</p> <p>On 4/8/14, a Nutrition Alert by the CDM, documented the resident lost 21.2 pounds in a 30 day time frame and the following interventions had been started since the change was noted: **1) Added Fortified Foods; *2) On Nutrition At Risk; *3) Snacks TID between meals; and, *The resident is consuming an average of 19% meals and 108 mL average per meal over the last 7 days."</p> <p>On 4/8/14, a Nutrition At Risk Review Progress Note, documented the resident's meal intake was "B[reakfast] 4 %, L[unch] 25 %, D[inner] 29% and Fluid Intake w/Meals 108 mL q/d [every day]. Current Wt: 4/3 was 166 pounds. Wt. Last Review: 3/20 172.8 pounds." The Summary section documented, "Res[ident] conts [continues] to decline. Res R [refuses] to eat quite a bit. Sent Nutr[itional] Alert to MD on 3/21 0 [no] response. Will send another one."</p> <p>On 4/9/14 an order for Ativan 0.5 mg daily at 5:00 PM was documented.</p> <p>On 4/9/14 at 1:40 PM, a physician telephone order documented, "Per RD recommendation House Supplement 120 cc PO TID with meals."</p> <p>The resident was admitted to hospice on 4/11/14 as documented on the</p>	F 325		9/15/14

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

PRINTED: 08/26/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/12/2014
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY 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)	(X6) COMPLETION DATE
F 325	<p>Continued From page 10 May Physician Order Report, dated 5/1/14.</p> <p>On 4/14/14, a Nutrition At Risk Review Progress Note by the CDM, documented the resident's meal intake was "B 21%, L 25%, D 7% and Fluid Intake w/Meals 111% mL q/d. Current Wt: 4/10 165.4 pounds. Wt Last Review: 4/3 166.6 pounds." The Summary Section documented, "Res[ident] now on hospice care. Con[ti]nes to eat and drink poorly. Updated care plan for hospice care."</p> <p>On 4/16/14, a telephone order documented, "Decrease suppl[ement] to 4 ounces QD [every day] w/th meds."</p> <p>On 4/21/14 an order for Seroquel documented to increase the dosage from 50 mg BID to 100 mg BID and an order for Ativan documented to increase the dosage from 0.5 mg BID to 1 mg BID.</p> <p>On 4/25/14, a Comprehensive Nutritional Assessment by the CDM, documented in the Evaluation and Summary Section, "No significant wt. variance. Received a regular diet. No recent labs available. Res[ident] on meds that has the potential for anorexia...Does feed self, however, needs cueing." The Recommendation & Plan section documented, "Wt loss, fair intake expected r/t [related to] hospice. Diet order appropriate. Cater to res[ident] & family preferences. Adjust as appropriate."</p> <p>The surveyor asked for the resident's Meal Intake Records during his length of stay at the facility. The facility was only able to provide the months of February and April of 2014. In February the</p>	F 325		9/15/14

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

PRINTED: 08/26/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/12/2014
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY 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 325	Continued From page 11 record documented the resident refused: Breakfast 3 times, Lunch 6 times and Dinner 11 times. In April the resident refused: Breakfast 16 times, Lunch 12 times (3 dates were left blank) and Dinner 8 times (2 dates were left blank).	F 325		9/15/14
	<p>On 8/12/14 at 3:50, the CDM was interviewed in the presence of the Administrator. The surveyor discussed the resident's Weight Flow Sheet with the CDM. When asked specifically why it took a week after losing 16.2 pounds to put the resident on the NAR list, the CDM stated, "I cannot answer that, I can't remember. The resident continued to lose weight and I don't know why." The surveyor asked the CDM about the physician's signature on the Nutrition Alerts, dated 3/21/14 and 4/8/14. However, the physician had not written a comment or orders to address the resident's weight loss. The CDM then stated, "I know and I don't know why he didn't date his signature." The surveyor discussed with the CDM the Comprehensive Nutritional Assessments, dated 2/5/14 and 4/25/14, which documented in the Evaluation & Summary Sections, "Res[ident] is on meds that has the potential for anorexia." The CDM stated she understood medications could affect a resident's intake. When asked about the resident's 34 pound weight loss during his admission at the facility, the CDM stated, "I know and I don't like it either."</p> <p>On 8/12/14 at 6:25 PM, the Administrator and DNS were made aware of the concerns with weight loss. No further information was provided by the facility.</p> <p>Resident #3 was harmed when he experienced severe weight loss of 34.8 pounds or, an 18%</p>			

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

PRINTED: 08/26/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/12/2014
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY 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 325	Continued From page 12 decrease, during his 106 day admission. The resident experienced a decrease in his ADL status. The physician failed to address the resident's weight loss in relation to medication use and anorexia. Additionally, there was a breakdown in communication and follow-up regarding the resident's weight loss between the CDM, RD, nursing and the resident's physician.	F 325		9/15/14
F 329 SS=G	483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced	F 329	F329 It is Safe Haven policy to provide each resident a drug regimen free from unnecessary drugs. Resident #3 was discharged from the facility. Resident #4 was discharged from the facility. All residents taking psychotropic medications have the proper diagnosis and/or are evaluated for possible gradual dose reduction or discontinued Each resident has a full assessment at a minimum upon admission, quarterly and with significant change. When a resident has had a significant change in behavior this is evaluated through the assessment process, through behavior narratives, through I&A reports, resident-resident investigation processes and through BCU meetings. These changes are documented in the resident's chart. Behavior care plans are updated to reflect any changes made as a result of the documented changes. Each time a behavior care plan is changed, a staff education goes out to the staff so that all staff are kept apprised of the change in care level for the resident. Staff development and nursing management are responsible for this training.	

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

PRINTED: 08/26/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/12/2014
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY 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 329	<p>Continued From page 13</p> <p>by: Based on record review and staff interview it was determined the facility failed to ensure a resident was free from unnecessary medications. This was true for 1 of 4 (#3) sampled residents. Resident #3 was harmed when he experienced increased somnolence, sedation, agitation, dizziness, weight loss, falls and a decline in ADLs as the result of multiple changes to his medication regime including a significant increase of his antipsychotic medication (Seroquel), an increase in his anti-anxiety medication (Ativan), and the addition of two other antipsychotic medications (Zyprexa and Thorazine) along with the use of two dementia medications (Namenda and Aricept). The facility did not document a thorough investigation of the root causes of the resident's behavioral and physical changes that led to and/or followed the medication changes, develop specific care plan interventions to address the resident's challenging behaviors or provide adequate justification for changes in the medications.</p> <p>Resident #3 was admitted to the facility on 1/22/14 with multiple diagnoses to include neurotic depression, dementia with behavioral disturbance, and malignant neoplasm - large intestine.</p> <p>The resident's Admission MDS dated 2/2/14 coded the following: * Short and Long Term memory impairment. * Inattention - easily distracted, out of touch, or difficulty following what is said. * No signs of hallucinations or delusions. * No Physical and/or verbal behavioral symptoms present. * No rejection of care.</p>	F 329	<p>The facility has implemented a process where any time a behavior is triggered that is outside what is considered normal behavior or what is care planned as typical behavior for a resident, the staff will document on a Behavior Narrative Sheet. These behaviors may include such issues as medical, pain, environmental, social triggers, and incidental. The nurse then investigates the situation for any predisposing factors, determines if any immediate changes need to take place, care plans any changes, and educates the staff. This information then goes forward to the DNS who reviews the information and determines if the resident needs to be reviewed further by the BCU team for further evaluation. The BCU team consists of the Program Director, the DNS, the Staff Development Director, The Administrator, the Clinical Care Coordinator, the secretary.</p> <p>PDR meets weekly to evaluate residents who are currently receiving psychotropic medications. They are reviewed for possible gradual dose reduction by the PDR team. Prior to this meeting the MS HCA, RN reviews the resident chart, interviews the resident, the staff, reviews documentation, orders, and medication regimen to evaluate and assess any need for changes in the current plan for the resident. The NP-C then documents the reasons for the GDR or the reasons why a GDR would be contraindicated. This is filed in the resident's permanent record. The Clinical Care Coordinator and/or the DNS sign off on this part of the record. When a GDR is contraindicated the DNS and nursing management monitors documentation for any indication of complications and presents all documentation for review immediately to the NP-C. This is then followed up at the next PDR meeting for discussion. The NP-C evaluates and visits in person with the residents as he determines necessary.</p>	9/15/14

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

PRINTED: 08/28/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/12/2014
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY 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 329	<p>Continued From page 14</p> <ul style="list-style-type: none"> * Independent with bed mobility, transfers, and walking in his room. * Supervision for ambulation on the unit and dressing. * Limited assist of one person with eating. * Extensive assist of one person with toileting, hygiene, and bathing. <p>The resident's Significant Change MDS dated 4/23/14 coded the following changes:</p> <ul style="list-style-type: none"> * Physical behaviors directed towards others. * Rejection of cares. * Supervision of one person for transfers. * Extensive assist of one person for ambulation, dressing, eating, toileting, personal hygiene and bathing. <p>The resident's admission Physician's Orders dated 1/22/14 documented the following:</p> <ul style="list-style-type: none"> * Ativan (Lorazepam) 0.5 mg PO [by mouth] BID [twice daily] - PRN [as needed] - for anxiety. * Ativan 0.5 mg PO BID - for anxiety. - Adverse reactions include sedation, agitation, unsteadiness, dizziness, disorientation, and change in appetite. * Celexa 10 mg PO daily - for depression. - Adverse reactions include somnolence, anxiety, agitation, anorexia, and decreased or increased weight. * Aricept 5 mg PO daily - for dementia. - Adverse reactions include dizziness, somnolence, anorexia, weight loss, and urinary frequency. * Seroquel 25 mg PO BID - psychosis. - Adverse reactions include somnolence and anorexia. * Namenda 10 mg PO BID - dementia. - Adverse reactions include aggressiveness, agitation, confusion, dizziness, somnolence, 	F 329	<p>The PDR consists of The NP-C, the MSHCA, RN, the DNS, the pharmacist, the Clinical Care Coordinator, the Program Director, and the secretary.</p> <p>When a patient is picked up by Hospice, the Hospice physician is the only physician who will be giving orders, unless another physician is consulted by the Hospice physician so as not to create confusion. Both the Medical Director and the Psychiatric team doctors will only give orders when asked to consult by the Hospice physician. Nurses are to receive consult orders first, through the Hospice physician.</p> <p>In-services:</p> <p>Nursing management in-serviced all nurses on: requesting appropriate orders for residents, having accurate information prior to calling for orders, making certain requests for psychotropics are not repeats or for previously d/c'd medications, KNOW YOUR HISTORY of your patient, his/her behaviors, his/her treatments, and his/her previous orders.</p>	9/15/14

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

PRINTED: 08/26/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/12/2014
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY 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 329	<p>Continued From page 15</p> <p>anorexia, weight loss, urinary frequency, incontinence, and UTI (Urinary Tract Infection).</p> <p>NOTE: The potential adverse reactions associated with the medications listed above are identified as such in the Nursing 2015 Drug Handbook: The medications that could cause a change in appetite or anorexia included: Ativan, Celexa, Arcept, Seroquel and Namenda.</p> <p>The resident's Behavior Care Plan dated 2/3/14 documented the following interventions: * "Approach [resident] when he is displaying s/s of depression/anxiety, ask what is wrong and what you can do to help. * Offer an activity. * [Resident] requires frequent cueing/redirection D/T [due to] dementia. * Staff to redirect [resident] to the bathroom frequently. * Staff to monitor [resident's] whereabouts."</p> <p>The Behavior Care Plan documented the following hand written intervention, "1:1 [one to one] staffing D/E [day and evening], 15 min[ute] [checks] nocs [night time]", however, there was no date to indicate when this intervention was added. The care plan did not identify what activities to offer or what staff were to do when the resident was not easily redirected as was demonstrated multiple times in the following notations, starting on 2/26/14.</p> <p>Resident #4's Physician Orders (P.O.), Hospice Notes (HN), Nurses Notes (NN), Medication Administration Record (MAR), Behavioral Care Plan (BCP), Psychiatric Notes (PN), 1:1 Shift Behavior Narrative Report (SBNR), Physician's Telephone Orders (T.O.), Psychotropic Drug</p>	F 329	<p>Monitoring:</p> <p>Nursing Administration will perform daily rounds two times per day. During these rounds they will be specifically checking for significant changes, weight loss/meal refusals, changes with psychotropic meds, PRNs, refusals of medications, I&As, and behaviors. These rounds began on 08/15/2014.</p> <p>Nursing Administration will receive and monitor all new orders on a daily basis for appropriateness. This process began on 08/15/2014.</p>	9/15/14

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

PRINTED: 08/26/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/12/2014
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY 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 329	<p>Continued From page 16</p> <p>Review (PDR), Behavior Management Guidelines (BMG), and Behavioral Flow Sheets (BFS) were reviewed and documented the following:</p> <ul style="list-style-type: none"> * NN dated 1/24, 1/25, 1/28, and 1/31, 2/1, 2/2 documented the resident was easily redirected. * PDR dated 2/6/14 documented; "Nursing staff reports the resident is currently pleasantly confused. The resident is compliant in the taking of his medications...The resident requires queuing [sic] by staff in completing his ADL's - otherwise resident is generally cooperative. The resident continues to demonstrate the behavior of wandering in the hall and being confused." * T.O. dated 2/7/14 documented, "DC (discontinue) PRN Ativan D/T non-use." * NN dated 2/7, 2/9, 2/10, 2/16, and 2/24/14 documented the resident was easily redirected. * NN dated 2/26/14 at 1800 [6:00 PM] documented, "Resident reported to have walked aimlessly [sic] into Mr. [resident's] room. Apparently when [Resident #3] was asked to leave he punched Mr. [Resident] on the [left] side of the face and left room. Profoundly demented." <p>The resident's record did not document the facility had attempted to determine the underlying cause of Resident #3's behavior towards another resident on 2/26/14.</p> <ul style="list-style-type: none"> * NN dated 2/27/14 at 1430 [2:30 PM] documented, "Res[ident] continues to try to go into other Resident's Rooms not easily redirected. When educated about going in other Resident's Rooms Res[ident] becomes agitated...Res[ident] took all meds as ordered Ativan and Seroquel not making resident sleepy nor manageable. He continues to need constant supervision." * NN dated 2/28/14 documented the following: 	F 329		9/15/14

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

PRINTED: 08/26/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/12/2014
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY 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 329	<p>Continued From page 17</p> <ul style="list-style-type: none"> - 10:00.AM documented, "Resident is alert [increased] wandering in the hallway. Redirected several times, hard to redirect." - 10:15 AM documented, "1:1 CNA in place as ordered." * T.O. dated 2/28/14 documented, "Increase Seroquel to 50 mg PO BID." * NN dated 3/5/14 at 2030 (8:30 PM) documented, "Resident constantly wandering this shift and requires constant redirection. Resident had very poor appetite at dinner." * NN dated 3/9/14 at 1300 (1:00 PM) documented, " Resident was inappropriate with 1:1 in the shower. Redirection effective." * PDR dated 3/11/14 documented, "Nursing staff reports the last few days the resident has been very sleepy. The resident continues to be confused two days ago the resident was pushing his 1:1 stating to them that he had to go to work. Nursing staff reports the resident's dietary status is poor. The resident continues to demonstrate the following behaviors of wandering, being intrusive and socially inappropriate. Nursing staff reports the resident's wandering activity level has lessened that [sic] last few days overall." * NN dated 3/12/14 at 2130 [9:30 PM] documented, "Res[ident] continues to be lethargic et [and] slept through most of shift. Resident woken up several times to eat et take meds, but res[ident] refused drink. Held B/p [blood pressure] med[ications] et [sic] digoxin d/t [decreased] B/p et[sic] pulse. Recent [increase] in Seroquel." * SBNR dated 3/14/14 at 6:11 AM documented, "He [the resident] got a little upset cause I tried [sic] to lay him down cause he said he was dizzy, he's pretty confused about where his bed and stuff is. He tried sitting on the floor thinking it was his bed...then he went the bathroom thinking his bed was in there..." 	F 329		9/15/14

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

PRINTED: 08/26/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/12/2014
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY 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 329	<p>Continued From page 18</p> <p>* SBNR dated 3/24/14 at 1857 (6:57 PM) documented, "Woke up resident said he was dizzy and had a little nausea wanted to go for a walk very confused keeps laying down and sitting up because of being dizzy." LN was notified.</p> <p>* Medication Chart Review (Pharmacy) dated 3/31/14 documented, "Seroquel dose doubled nurse rec[omended] not using lorazepam Q AM anymore."</p> <p>* Drug Therapy Alert dated 4/2/14 documented, "Dose too high (Lorazepam TAB 0.5 mg) - lorazepam 0.5 mg BID may be excessive as quetiapine (Seroquel) does has just been doubled on 2/28/14 from 25 mg BID to 50 mg BID for psychosis. Nurse notes that patient is sleeping frequently since the quetiapine increase and that patient could do without the lorazepam dose at bedtime. Please consider reducing the lorazepam dose to 0.5 mg Q AM."</p> <p>The resident's record did not document the facility had attempted to determine the underlying cause of the resident's somnolence, dizziness, and unsteadiness.</p> <p>* T.O. dated 4/4/14 at 2:30 PM documented, "DC 1700 (5:00 PM) Ativan r/t pDR [sic] recommendation. Urinalysis in AM [for increased] agitation.</p> <p>* SBNR dated 4/8/14 at 1300 (1:00 PM) documented the resident was being moved to a different room, [Resident] got upset with aid [sic] and punched him twice in the mouth."</p> <p>There was nothing documented in the resident's record to explain why the resident was being moved to another room or if the facility had talked to the resident about changing rooms and/or how the resident felt about it. Additionally, the facility</p>	F.329		9/15/14

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

PRINTED: 08/26/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/12/2014
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY 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 329	<p>Continued From page 19</p> <p>did not identify the risk for escalated behaviors such as increased wandering, confusion, intrusive behavior, agitation, and aggression associated with the room change.</p> <p>* NN dated 4/8/14 at 11:35 PM documented, "Hospice consult with [Hospice Agency] per families request.</p> <p>There was nothing documented in the resident's record which identified what significant change had occurred in the resident's medical condition to indicate the resident had declined to the point he required Hospice services.</p> <p>* NN dated 4/9/14 at 5:00 PM documented, "Res[ident] started shift wandering halls et [sic] unable to understand his room has been moved. Resident wanders into old room and with redirect will become combative with staff. Resident is unsure of new roommate as soon as roommate was out to smoke he [Resident #3] went in new room, when the roommate returned [Resident #3] left room. Staff reassured res[ident] that roommate was okay but until roommate was in bed, [Resident #3] refused to go into room."</p> <p>* T.O. dated 4/9/14 documented, "Restart Ativan 0.5 mg PO q [every] 1700 [5:00 PM] [and] (AM dose continue)."</p> <p>The facility on 4/9/14 moved Resident #3, with an identified baseline of confusion, aggression, and intrusive wandering to a new room. On 4/9/14 after the facility moved the resident the facility received an order to restart the resident's 5:00 PM dose of Ativan related to increased agitation.</p> <p>The facility failed to rule out the root cause of the exacerbated behaviors related to the room</p>	F 329		9/15/14

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

PRINTED: 08/26/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/12/2014
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY 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 329	<p>Continued From page 20 change or justify restarting the Ativan which the pharmacist identified as possibly being "excessive" on 4/2/14.</p> <p>* NN dated 4/10/14 documented the following: - 8:25 PM, "Agitated hitting at 1:1 aide [Physician] notified. New order Zyprexa Zydys [sic] 5mg IM, [to be given] now." - 8:30 PM, "Resident agitated this shift. Res[ident] punched staff. Res[ident] cont[inues] to be redirected. RN gave res[ident] Zyprexa IM this evening. Res[ident] did rest from 1700-1900 [5:00-7:00 PM]. Res[ident] wanders and is intrusive. Res[ident] was compliant [with] med[ications]." * T.O. dated 4/12/14 documented, Resident admitted to [Hospice Agency] care. * NN dated 4/12/14 documented the following: - 1345 [1:45 PM], Final UA C&S equal/greater than 100,000 Ecoll. Physician notified and stated it was, likely contaminated." - 1842 [6:42 PM], "Notified hospice of cx [culture] results POA refused to treat as resident is comfortable." There was nothing documented in the resident's Hospice record or medical record that the facility had a discussion with the POA to explain risk versus benefits of treating a UTI. * SBNR dated 4/12/14 documented from 6:00 AM until 12:00 PM the resident remained in bed, did not eat, and did not get up to use the bathroom. * SBNR dated 4/12/14 documented: - 2:00 PM to 10:00 PM, "[Resident] was asleep the hole [sic] shift I tried waking him up once or twice but he didn't want to get up. He also didn't eat or drink anything as well." - 5:50 PM, "Resident refused eating, became</p>	F 329		9/15/14

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

PRINTED: 08/26/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/12/2014
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY 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 329	<p>Continued From page 21</p> <p>agitated and aggressive. Ensured safety and backed off. Behavior improved."</p> <p>* NN dated 4/12/14 at 8:00 PM documented, "Resident continues to remain in bed [with] eyes closed. Resident to be pale et [sic] breathing slowly et [sic] shallow. Res[ident] woken for med[ications] et [sic] dinner. Resistive to direction. Res[ident] refused dinner."</p> <p>The resident's record did not document on 4/13, 4/14, 4/15 any follow-up related to the resident's pale skin color, shallow breathing, or refusal of meals on 4/13.</p> <p>* T.O. dated 4/16/14 at 6:45 AM documented, "D/C Coumadin, Fenofibrate, ASA, Digoxin, Aricept, Lisinopril, Glucosamine, Vitamin D, Sotalol, and Celexa."</p> <p>* T.O. dated 4/16/14 at 2:00 PM documented, "Start Namenda XR 28 mg PO daily when current IR Namenda is exhausted."</p> <p>* SBNR dated 4/16/14 documented the following: - 4:30-7:30 PM, "Res[ident] was very confused. Wanting to go the airport. I explained he did not have a car." - 7:00 PM, Res[ident] would not go lay down because there was someone in his room (roommate)."</p> <p>The resident's record did not document why the above medications were discontinued, nor did it document why the Namenda dose was increased.</p> <p>* PDR dated 4/17/14 documented the following: - "Change in drug therapy is contraindicated at this time because the resident is on optimal dose and is clinically stable." - "Nursing staff reports the resident was admitted</p>	F 329		9/15/14

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

PRINTED: 08/26/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/12/2014
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO	STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY 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 329	<p>Continued From page 22</p> <p>to hospice care on 12 April 2014. Nursing staff reports the resident demonstrates significant behaviors: hitting, kicking, punching at staff; wandering a lot in the hallway and being intrusive - attempting to go into other residents' room...Nursing staff reports that when the resident is awake he is constantly walking - the resident will also eat while he is walking - staff are unable to re-direct the resident to sit down and eat meals. This resident is compliant in taking of his medications. The resident is resistive and difficult to re-direct in completing his ADL's and other related activities..."</p> <p>It was unclear how the facility determined changes and/ or GDR's to the resident's current identified drug therapy was contraindicated at this time because the resident is on "optimal dose and is clinically stable," when the resident's record documented the resident had been displaying increased behaviors.</p> <p>* NN dated 4/17/14 at 7:35 PM documented, "New orders: - Thorazine 50 mg po q 4 hrs prn anxiety and combativeness. - Thorazine 50 mg po qhs scheduled. - Lorazepam 1mg/ml gel PLO: Apply to inner wrist's...and give 1 mg q 2 hrs prn anxiety." * SBNR dated 4/18/14 documented: - 6:00 AM to 7:00 AM, "Resident asleep in bed." - 7:45 AM to 8:45 AM, "Woke resident up for breakfast. Refused. Woke up to go to toilet, then back to bed..." - 11:00 AM to 11:15 AM, "Awake walking around very confused and agitated. Walking and hes [sic] very dizzy not feeling well." - 12:00 PM, "In wheel chair walking around." * SBNR dated 4/19/14 documented:</p>	F 329		9/15/14

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

PRINTED: 08/26/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/12/2014
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY 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 329	<p>Continued From page 23</p> <p>- 2:00 PM to 5:00 PM, resident sleeping.</p> <p>- 6:00 PM to 8:00 PM, "Resident needs to use bathroom, very confused wandering, and dizzy. Wanting to wander around he doesn't know where he is or what he is doing here at [Facility]. Resident has not been wanting to stay in room his roommates [sic] radio is to [sic] loud and it bothers him. Been trying to redirect resident to his room he wants to walk around but gets dizzy and he acts like he is going to fall over. (makes me nervous)"</p> <p>* P.O. on 4/19, 4/21, 4/22, and 4/25 documented the resident received Thorazine 50 mg po at bed time and Thorazine 50 mg PO q 4 hrs pm times one dose on each day with the scheduled Thorazine. On these days the resident received a total of 100 mg of Thorazine.</p> <p>NOTE: Federal guidance at F-329, Unnecessary Medications, identified the following Daily Dose Thresholds for Antipsychotic Medications Used to Manage Behavioral Symptoms Related to Dementing Illnesses...The daily dose for Thorazine is 75 mg."</p> <p>* SBNR dated 4/20/14 documented:</p> <p>- 3:00 PM, "Resident got up to go to the bathroom and wanted to wander I redirected him to go to the Easter Sunday service, he was hallucinating a dog during the service and got very dizzy almost fell over as I was trying to get him back to his room."</p> <p>- 5:30 PM, Resident is very confused, is very difficult to keep in his room. Every time we walk around he is about to fall over his mind changes every 5 min[utes] or so doesn't know where he is, who I am or who anyone is for that matter."</p> <p>- 7:15 PM, "Resident keeps wanting to wander telling me he needs his car...most of the time when we are talking he makes no since [sic]. Resident has forgot to tie his shoelaces and go</p>	F 329		9/15/14

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

PRINTED: 08/26/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/12/2014
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO	STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY 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 329	<p>Continued From page 24</p> <p>[sic] to the bathroom if he sits down to urinate he gets it all over the floor, if he stands up he gets it all down the front of his pants..."</p> <p>* Hospice Note dated 4/20/14 from 2:00 PM to 10:00 PM documented, "Res[ident] amb[ulating] in halls [with] unsteady gait et [sic] 1:1 staff at res[ident] side et [sic] and gait belt in use. Res[ident] wanders in attempts to go in other res[ident] room requires constant redirect. Res[ident] confused et [sic] when asked question unable to answer properly unless simple yes/no it is majority of time appropriate...Difficulty voiding in toilet et [sic] urine getting on his pants et [sic] floor..."</p> <p>* Hospice Note dated 4/21/14, "Pt lying in bed pleasant affect nurse reports pt has had an active morning...Pt denied pain, pt was attempting to communicate yet speech is unclear and garbled. No problem behaviors reported."</p> <p>* T.O. dated 4/21/14 at 8:00 PM documented the following order, "Increase Ativan to 1 mg PO BID for agitation. Increase Seroquel to 100 mg PO BID for psychosis."</p> <p>It could not be determined why the resident's Ativan and Seroquel were increased on 4/21/14. The resident had been experiencing increased Incontinence and confusion, garbled speech, unsteady gate, and dizziness after the Thorazine was ordered on 4/17/14 and the Ativan was increased.</p> <p>* SBNR dated 4/22/14 documented: - "3:15 PM, [Resident] started to get really irritated he tried walking in other residents rooms so I would gently grab his arm and he started to swear at me and shove me. - 4:20 PM, [Resident] tried sitting down and almost missed the chair then started to fall to the</p>	F 329		9/15/14

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

PRINTED: 08/26/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/12/2014
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY 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 329	Continued From page 25 ground before I caught him. Then he decided to lay down on the floor in the dining room." - 8:15 PM, "Resident finally fell asleep he was very tired but could not get comfortable c/o to much noise, talking in the hall outside his door. When I got with the resident he didn't have any behaviors just wanted to look for car, I explained to him about car then he was ok." * Hospice Note dated 4/23/14 at 11:25 (AM/PM not documented), "Pt lying on right side sleeping opened eyes to name. VS and assess[ment] completed [with] pt sleeping. 1:1 states he's been asleep all day." * SBNR dated 4/24/14 documented: - 9:00 AM, "Resident awoke and used the toilet to urinate. Resident needed physical assistance. Resident was pleasant and cooperative. Resident went back to bed and fell asleep." - 9:50 AM, "Resident's family came into visit. Resident continued to sleep. Resident would not wake up to visit family." - 4:45 PM to 5:45 PM, in hall - sitting, dizzy, confused (reported to nurse and checked B.P.)" * T.O. dated 4/25/14 documented, "Thorazine 50 mg q 1 tab po q 5 hrs prn for anxiety/combativeness." * Hospice Note dated 4/25/14 (AM/PM not documented), "Pt resting in bed aid reports pt was slightly agitated wanted to be left alone. Pt was tired non-combative, increased fatigue [takes] 15 steps and needs to rest." * Hospice Note dated 4/28/14 at 2:30 AM documented, "Pt noted to be anxious and combative this evening. Pt sustained a minor fall while he was hitting his 1:1. He reportedly lost his balance in the altercation. Pt assessed [and] no apparent injuries to note. Pt laid down and fell asleep shortly, Pt was noted later in the night to be figidity [sic] and hallucinating. PRN Ativan	F 329		9/15/14

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

PRINTED: 08/26/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/12/2014
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO	STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY 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 329	<p>Continued From page 26</p> <p>given which was somewhat helpful."</p> <p>* T.O. dated 5/2/14 at 1:30 PM documented, "Thorazine 50 mg po daily at 3:00 PM."</p> <p>* SBNR dated 5/3/14 documented the following:</p> <ul style="list-style-type: none"> - 2:00 PM, "Stayed sleeping woke up few times. Mumbling..." - 3:30 PM, "[Resident] was hard to get to toilet and changing his attend took me 10 minutes to try and get the dirty one off. When he just kept not wanting changed I educated him. Res[ident] with clean attends." - 5:15 PM, "[Resident] kept sliding off bed onto the floor. Keeps wanting to sleep got help from another CNA to get back into bed." - 5:30 PM, "[Resident] took a few bites of his food yet refuses and states he wants to sleep. I try to talk to [Resident] but resident refuses to say anything else. He did take a few bites but kept spitting it on the floor." <p>* SBNR dated 5/6/14 documented the following:</p> <ul style="list-style-type: none"> - 3:30 PM, "Resident refuses to wear O2 (oxygen)." - 3:45 PM to 4:00 PM, "Resident delusional, agitated, and aggressive. Resident tried to go into another resident's room redirection did not work, resident became agitated and raised arm to hit aid." <p>* NN dated 5/8/14 at 2:30 PM documented, "Res[ident] discharged to [Assisted Living] meds sent [with] resident pleasant mood."</p> <p>On 8/12/14 at 3:30 PM the DNS, ADON, and Care Plan nurse were interviewed. The surveyor asked for the clinical rationale/justification for the use of the antipsychotic medications including the dose increases and how the interdisciplinary team was monitoring the resident's response to the medication. The DNS stated the facility could not provide justification for the use of the</p>	F 329		9/15/14

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

PRINTED: 08/26/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/12/2014
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO	STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY 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 329	Continued From page 27 antipsychotic's or the dose increases. The surveyor asked if the facility was documenting the signs and symptoms of adverse reactions related to the antipsychotic medications and if the physician was notified. The DNS and ADON did not respond. The surveyor asked the DNS if the pharmacist had performed a medication review when additional antipsychotic medications were ordered or existing antipsychotic's were increased. The DNS did not respond. The surveyor asked if the facility had a clinical rationale for why a particular medication, dose, or duration was appropriate for Resident #3 despite the risks associated with the medication and the combination of medications. The DNS stated the facility could not provide that information.	F 329		9/15/14
F 514 SS=D	Resident #3 was harmed when 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	F 514	F514 It is Safe Haven's policy to maintain clinical records on each resident in accordance with accepted professional standards and practices. Hospice notes will be maintained in the chart at all times.	

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

PRINTED: 08/26/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/12/2014
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO	STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY 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>resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to maintain accurate, complete and organized clinical records. This was true for 1 of 4 (#3) sampled residents. This created the potential for medical decisions to be based on inaccurate information. Findings included:</p> <p>Resident #3 was admitted to the facility on 1/22/14 with diagnoses of dementia with behavioral disturbance, depression, atrial fibrillation and depression.</p> <p>The May Physician Order Report, dated 5/1/14, documented the resident was admitted to hospice on 4/11/14.</p> <p>The resident's medical record did not contain any hospice visit note reports but was found to contain hospice physician verbal orders for the following dates: *4/10/14; *4/17/14; *4/25/14; and, *5/8/14 - discharge from the facility and transfer to another facility.</p> <p>On 8/12/14 at 11:55 AM the facility provided 163 pages of hospice paperwork which included the plan of treatment, visit note reports and physician verbal orders which had been faxed to the facility</p>	F 514	<p>In-service:</p> <p>Safe Haven evaluated all Hospice contracts. Safe Haven met with each Hospice company and went over our policy regarding medical records and maintaining chart notes, orders, and all pertinent information within the chart at all times. Each Hospice team was also made aware that each time a resident is placed onto Hospice an initial care conference will be held and at that time the rules will be reviewed again at that time.</p> <p>Monitoring:</p> <p>Medical Records will audit all Hospice charts for completeness weekly X4 weeks and monthly X3 months thereafter. These audits started 09/11/2014.</p>	9/15/14

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

PRINTED: 10/29/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/12/2014
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY 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 by a local Home Health and Hospice agency.</p> <p>On 8/12/14 at 3:30 PM, the DNS was interviewed regarding the missing hospice paperwork which had been faxed to the facility but was not found in the chart. The DNS stated, "It should have been in the closed record."</p> <p>On 8/12/14 at 4:25 PM, the Administrator and DNS were informed of the concern with complete and accurate medical records. No further information was provided by the facility.</p>	F 514		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001620	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 08/12/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

SAFE HAVEN CARE CENTER OF POCATELLO 1200 HOSPITAL WAY
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	16.03.02 INITIAL COMMENTS The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2. The following deficiencies were cited during the State licensure complaint survey of your facility. The surveyors conducting the survey were: Rebecca Thomas, RN, Team Coordinator Amy Barkley, RN, BSN.	C 000		
C 147	02.100,05,g Prohibited Uses of Chemical Restraints g. Chemical restraints shall not be used as punishment, for convenience of the staff, or in quantities that interfere with the ongoing normal functions of the patient/resident. They shall be used only to the extent necessary for professionally accepted patient care management and must be ordered in writing by the attending physician. This Rule is not met as evidenced by: Refer to F-329 as it relates to the use of unnecessary drugs.	C 147	Please refer to F329 Response.	9/15/14
C 156	02.100,08,a Prior Notification of Next of Kin a. Patients/residents shall not be transferred or discharged on the attending physician's order without prior notification of next of kin, or sponsor, except in cases of emergency. Patients/residents shall be counselled prior to transfer or discharge.	C 156	Please refer to F157 response	9/15/14

RECEIVED
OCT 14 2014
FACILITY STANDARDS

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

Judith A. Moore

TITLE

Administrator

(X6) DATE

9/15/14

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001620	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/12/2014
--	---	---	---

NAME OF PROVIDER OR SUPPLIER: SAFE HAVEN CARE CENTER OF POCATELLO
STREET ADDRESS, CITY, STATE, ZIP CODE: 1200 HOSPITAL WAY 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 156	Continued From page 1 This Rule is not met as evidenced by: Please refer to F-157 as it relates to notification of medicare non-coverage.	C 156		
C 787	02.200,03,b,III Fluid/Nutritional Intake III. Adequate fluid and nutritional intake, including provisions for self-help eating devices as needed; This Rule is not met as evidenced by: Please refer to F-325 as it relates to weight loss.	C 787	Please refer to F325 response.	9/15/14
C 803	02.200,04,f Observed for Reactions f. Patients/residents are observed for reactions to medications and if a reaction occurs, it is immediately reported to the charge nurse and attending physician; This Rule is not met as evidenced by: Please refer to F329 as it relates to unnecessary medications and monitoring for adverse effects.	C 803	Please refer to F329 response.	9/15/14
C 881	02.203,02 INDIVIDUAL MEDICAL RECORD 02. Individual Medical Record. An individual medical record shall be maintained for each admission with all entries kept current, dated and signed. All records shall be either typewritten or recorded legibly in ink, and shall contain the following: This Rule is not met as evidenced by: Please refer to F-514 as it relates to complete medical records.	C 881	Please refer to F514 response.	9/15/14



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. 'BUTCH' OTTER -- Governor
RICHARD M. ARMSTRONG -- Director

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

August 26, 2014

Steve Gannon, Administrator
Safe Haven Care Center of Pocatello
1200 Hospital Way
Pocatello, ID 83201-2708

FILE COPY

Provider #: 135071

Dear Mr. Gannon:

On August 12, 2014, a Complaint Investigation survey was conducted at Safe Haven Care Center of Pocatello. Becky Thomas, R.N. and Amy Barkley, R.N. conducted the complaint investigation.

The following documents were reviewed:

- The identified resident's closed record, along with the records of three other sampled residents;
- Grievances from December 2013 to June 2014; and
- Incident/Accident Reports from December 2013 to June 2014.

Facility staff, which included the administrator, Director of Nursing Services and dietary manager, were interviewed.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00006584

ALLEGATION #1:

The complainant stated the resident weighed 245 pounds when he was admitted to the facility in December 2013, and during his stay, he lost 60 pounds and dropped to 185 pounds.

FINDINGS #1:

Based on records reviewed and staff interviewed, it was determined the facility failed to identify weight loss trends and implement interventions in a timely manner after the resident's weight loss became significant. The resident was harmed when he experienced a severe weight loss of 18%.

CONCLUSIONS:

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

ALLEGATION #2:

The complainant stated the identified resident laid in bed for two months without eating because he was over-sedated and the facility would not put his dentures in. The complainant stated the resident slept for 18-20 hours a day and the facility insisted the resident be on a twenty-four hour watch.

FINDINGS #2:

Based on records reviewed and staff interviewed, it was determined the facility failed to ensure this resident was free from unnecessary medications. The resident was harmed when he experienced increased somnolence, sedation, agitation, dizziness, weight loss, falls and a decline in activities of daily living as the result of multiple changes to his medication regime; including a significant increase of his antipsychotic medication, an increase in his anti-anxiety medication and the addition of two other antipsychotic medications, along with the use of two dementia medications. The facility did not document a thorough investigation of the root causes of the resident's behavioral and physical changes that led to and/or followed the medication changes, develop specific care plan interventions to address the resident's challenging behaviors or provide adequate justification for changes in the medications.

The facility was cited at F329 for the use of unnecessary medications.

CONCLUSIONS:

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

ALLEGATION #3:

The complainant stated the identified resident was placed on hospice because the facility told the complainant the resident was dying.

FINDINGS #3:

The facility's hospice contract was reviewed. It included the care and services to be provided by the hospice agency.

The identified resident's medical record documented the hospice agency evaluated the resident. His medical condition met the criteria for hospice services.

The hospice care plan was reviewed. It appropriately identified the hospice agency's responsibilities.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

The complainant stated the facility charged the resident \$9200.00 dollars for the resident's stay. The complainant stated \$4000.00 dollars was for 24-hour watch and an additional \$3000-\$3200 dollars was for wound care.

The complainant stated the paperwork sent with the resident upon discharge from the facility identified the resident required wound care. The complainant stated the receiving facility completed a head to toe assessment on the resident upon admission and did not identify any skin issues.

FINDINGS #4:

The Bureau of Facility Standards does not have regulatory oversight related to billing issues. The complainant may want to refer these billing concerns to the insurance company responsible for paying these costs.

CONCLUSIONS:

The Bureau of Facility Standards does not have regulatory oversight related to billing issues.

Based on the findings of the complaint investigation, deficiencies were cited and included on the

Steve Gannon, Administrator
August 26, 2014
Page 4 of 4

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

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

Sincerely,

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

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

LKK/dmj