



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 1482**

August 27, 2014

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

Provider #: 135115

Dear Ms. Oswald:

On **August 20, 2014**, a Recertification and State Licensure survey was conducted at Eastern Idaho Regional Medical Center - Transitional Care Unit by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be one that comprises a pattern that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

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

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

CMS-2567 and State Form, Statement of Deficiencies and Plan of Correction in the spaces provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **September 9, 2014**. Failure to submit an acceptable PoC by **September 9, 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:

- 1) • What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- 2) • How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- 3) • What measures will be put in place or what systemic change will you make to ensure that the deficient practice does not recur;
- 4) • 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;
- 5) • Include dates when corrective action will be completed in column (X5).

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

Renae Oswald, Administrator  
August 27, 2014  
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- The administrator must sign and date the first page of both the federal survey report, Form CMS-2567 and the state licensure survey report, State Form.

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

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS), if your facility has failed to achieve substantial compliance by **September 24, 2014 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **September 24, 2014**. A change in the seriousness of the deficiencies on **September 24, 2014**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **September 24, 2014** includes the following:

Denial of payment for new admissions effective **November 20, 2014**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **February 20, 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, they will provide you with a separate formal notification of that determination.**

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

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional

Renae Oswald, Administrator  
August 27, 2014  
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Office or the State Medicaid Agency beginning on **August 20, 2014** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the noncompliance at the time of the revisit, if appropriate.

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

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

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

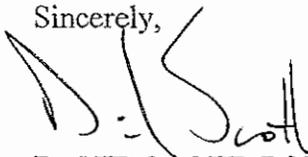
- BFS Letters (06/30/11)

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

This request must be received by **September 9, 2014**. If your request for informal dispute resolution is received after **September 9, 2014**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,



DAVID SCOTT, R.N., Supervisor  
Long Term Care

DS/dmj  
Enclosures

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

PRINTED: 08/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  08/20/2014
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NAME OF PROVIDER OR SUPPLIER  EASTERN IDAHO REGIONAL MEDICAL CENTER - TCU	STREET ADDRESS, CITY, STATE, ZIP CODE 3100 CHANNING WAY, 83404-7533 IDAHO FALLS, ID 83403
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000 INITIAL COMMENTS

F 000

The following deficiencies were cited during the annual federal recertification and state licensure survey of your facility.

The surveyors conducting the survey were: Rebecca Thomas, RN, Team Coordinator, and Nina Sanderson, BSW, LSW

The survey team entered the facility on August 18, 2014, and exited on August 20, 2014.

Survey Definitions:

- ADL = Activities of Daily Living
- BFS = Bureau of Facility Standards
- BIMS = Brief Interview for Mental Status
- cm = Centimeters
- CNA = Certified Nurse Aide
- DON/DNS = Director of Nursing
- FDA = Food and Drug Administration
- LN = Licensed Nurse
- MAR = Medication Administration Record
- MDS = Minimum Data Set assessment
- mg = milligrams
- OT = Occupational Therapist
- PRN = As Needed
- TCU = Transitional Care Unit

F 154 SS=D 483.10(b)(3), 483.10(d)(2) INFORMED OF HEALTH STATUS, CARE, & TREATMENTS

F 154

The resident has the right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition.

The resident has the right to be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect

1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #5 has been discharged. In an effort to ensure over-all wellbeing of all residents, relating to medicine changes and newly added medications, including those with black box medications warnings, it is the practice of the nursing staff to educate the patients on pertinent information relating to the change in medications or the newly added medication.

9/5/14

RECEIVED  
SEP 31 2014  
FACILITY STAFF

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

TITLE

(X6) DATE

NHA

9/29/30

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

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	<p>Continued From page 1 the resident's well-being.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility did not ensure a resident's representative was informed of the FDA black box warning for an antipsychotic medication. This was true for 1 of 2 residents (#5) sampled for antipsychotic use. The deficient practice had the potential to cause harm when a resident's representative did not have the opportunity to make an informed decision regarding the potential risks and benefits when this medication was ordered for the resident's use. Findings included:</p> <p>Resident #5 was admitted to the facility on 8/14/14 with a primary diagnosis of acute cholecystitis.</p> <p>Resident #5 had not yet had an MDS completed at the time the survey was conducted.</p> <p>Resident #5's medication orders upon admission to the facility included the antipsychotic Olanzapine (Zyprexa) 2.5 mg daily at bedtime. No diagnosis was listed for this medication.</p> <p>On 8/17/14, a physician's order for Resident #5 documented the addition of Seroquel 25 mg daily at bedtime, with a diagnosis of dementia related psychosis.</p> <p>The 2015 Nursing Drug Handbook documented: Zyprexa, page 1040: "Black Box Warning: Drug may increase risk of CV [cardiovascular] or infection-related death in elderly patients with</p>		<p>2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken? All residents may be affected.</p> <p>3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? When a new medication is ordered or there is a change in medication, education is completed by the nurse at the time of administration. Once per week pharmacy performs a review of resident medications. If there are any additional black box warnings or other concerns, that information will be presented by the nurse or pharmacist to the resident and/or family within 24 hours of the pharmacy review.</p> <p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? With a start date of 11th of September, on a weekly basis for 2 months, then quarterly for one year, the TCU Nurse Manager, Director, or Clinical Team Lead will review 3-5 resident's new medications. A chart audit will be performed to verify appropriate education of the resident as evidenced by documentation.</p>	

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F 154	<p>Continued From page 2</p> <p>dementia. Olanzapine isn't approved to treat patients with dementia-related psychosis." Seroquel, page 1025: "Black Box Warning: Drug isn't indicated for use in elderly patients with dementia-related psychosis because of increased risk of death from CV disease or infection."</p> <p>On 8/19/14 at 9:40 AM, the resident's representative stated the resident had been admitted to the facility following "gallbladder surgery" and had a difficult time recovering from the anesthetic. The resident's representative stated the facility had started the resident on a "sleeping pill" two nights ago, and was hopeful the resident would show improvement. The resident's representative was not sure of the exact medication the facility had started, and was not aware of any concerns with the use of either medication for the resident.</p> <p>On 8/19/19 at 11:10 AM, the DNS was asked if the resident's representative had been informed of the Black Box Warning for the Zyprexa the resident was receiving upon admission, or that the Seroquel started for the resident was an antipsychotic medication also bearing a Black Box Warning. The DNS stated she did not think the facility had done that, but she would check.</p> <p>On 8/19/14 at 1:00 PM, the Administrator and Pharmacist met with the surveyors. The Pharmacist stated he was not aware of a specific regulatory requirement for the facility to inform residents or their representatives about the FDA Black Box Warning. The Pharmacist expressed concern such notifications would be too time consuming to be realistically implemented.</p> <p>[NOTE: Federal guidance at F 154 documented,</p>	F 154		

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F 154	Continued From page 3 "Informed in advance" means that the resident receives information necessary to make a health care decision, including information about his/her medical condition and changes in medical condition, about the benefits and reasonable risks of the treatment, and about reasonable available alternatives."  On 8/19/14 at 3:00 PM, the Administrator and DNS were informed of the surveyor's findings. The facility offered no further information.	F 154			
F 156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES  The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.  The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to	F 156	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The Residents Rights and Responsibilities form has been updated to include the necessary information to educate the residents and their families regarding the ability: a. to receive copies of their medical records, b. the time frames they can expect to receive them, and c. placing their money into an account and what interest rates apply. The current residents have received a copy of this form and have signed/dated to establish their understanding. It is also provided in all new admission packets.	9/5/14	

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F 156	<p>Continued From page 4</p> <p>the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance</p>	F 156	<p>2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken? All residents have potential to be affected.</p> <p>3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? The updated form, with the revision date, was placed in the patient admissions packet as of 9/5/14. This is given upon admission to every resident or their representative. The admitting nurse goes over the form, provides verbal instructions and gives the folder to them. There is a signature and date obtained to verify receipt by the patient or representative.</p> <p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? A weekly audit of the admission packets will be completed for the first month, then on a quarterly basis afterward to ensure that the correct form is included as evidenced by the revision date. TCU Nurse Manager or Director will perform these audits.</p>	

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F 156	<p>Continued From page 5 directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>This REQUIREMENT is not met as evidenced by: Based on review of the facility's Admissions Agreement and staff interview, it was determined the facility did not inform residents of all of their rights at the time of admission. This was true for any resident admitted to the facility. Findings included:</p> <p>The facility's Admission Agreement documented: **"You have the right to inspect and purchase photocopies of your records." However, there was no information regarding how quickly a resident could expect to see or receive copies of their record. The Admission Agreement did not include information regarding potential cost of photocopies, nor did it inform the resident they could make such a request either verbally or in writing. **"You have the right to be fully informed of your total health status." However, the Admission Agreement did not inform the resident the information could or would be provided in a</p>	F 156		

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F 156	<p>Continued From page 6</p> <p>language understandable to the resident.</p> <p>*"The facility must manage your deposited funds with your best interests in mind. Your money will not be commingled with facility funds." However, there was no documentation informing the resident deposited funds of a certain amount would be placed in an interest-bearing account.</p> <p>On 8/19/14 at 1:30 pm, the Administrator was asked about the above items in the facility's admission agreement, and if that information was provided to the residents. The Administrator stated, "If you didn't see it, it isn't there."</p> <p>On 8/20/14 at 3:00 PM, the Administrator and DNS were informed of the findings. The facility offered no further information.</p>	F 156		
F 166 SS=E	<p>483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES</p> <p>A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on review of the facility's grievances and staff interview, it was determined the facility did not act promptly to resolve resident grievances. This was true for any resident having filed a grievance with the facility. The deficient practice had the potential for harm if residents had concerns which were not addressed by the facility. Findings included:  On 8/20/14 at 8:25 AM, surveyors reviewed the</p>	F 166	<ol style="list-style-type: none"> <li>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? A grievance form has been created. Included are areas for the date the grievance was received, the date the grievance was resolved, specific information regarding details of the residents' concerns, what the facility's investigations revealed and whether the resident was satisfied with the facility's resolution. Nursing staff received written education on this procedure.</li> <li>2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken? All residents may be affected.</li> </ol>	9/5/14

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F 166	<p>Continued From page 7</p> <p>facility's grievance file. The file consisted of a two-page typed document, with a brief description of various residents' complaints, along with a brief description of the facility's resolution. The facility's resolution did not consistently address all of the items identified in the complaint. Additionally, the file did not document:</p> <ul style="list-style-type: none"> <li>*The date the grievance was received;</li> <li>*The date the grievance was resolved;</li> <li>*Specific information regarding details of the residents' concerns;</li> <li>*What the facility's investigation revealed;</li> <li>*Whether the resident was satisfied with the facility's resolution.</li> </ul> <p>On 8/20/14 at 9:20 AM, the Social Worker (SW) was interviewed about the facility's grievance process. The SW stated that, in general, if a resident had a concern, he/she would tell the nurse. The nurse would communicate verbally to the SW, if it was felt the matter warranted further investigation. Once received by the SW, verbal communication would take place between the SW and the Administrator. They would decide whether or not the concern would be treated as an official grievance, and whether or not to enter the concern into the facility's grievance file. The SW stated the grievance file had no additional information aside from what had been provided to surveyors.</p> <p>On 8/20/14 at 11:30 AM, the Administrator stated there was an informational booklet in each resident room, in a plastic pocket on the wall. The booklet contained a toll-free number a resident could call to report a grievance to the corporate office. The Administrator stated the facility felt this was adequate to ensure residents could file a grievance. However, the Administrator did not</p>	F 166	<p>3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? The grievance form has been placed in the admission packets. This packet, including the grievance form and an envelope, is given to the resident/family on day of admission and a verbal explanation will be given by the admitting nurse. If more than one grievance form is needed, additional grievance forms and envelopes are located in the TCU Dining Room in a folder with appropriate label for identification. The residents may fill out as many forms as they feel are needed. Each will be investigated separately. If a complaint/grievance is perceived by resident/family the instructions are to fill out the form and seal it in the envelope that is provided, and place it in a drop box which is provided in the TCU Dining Room. The Social Worker or Charge Nurse will check this box twice/day, a.m. and p.m. When grievances are received, the Social Worker, Charge Nurse, TCU Nurse Manager, Director or Clinical Team Lead will begin investigation in a timely manner, but no longer than 1 working day. This investigation includes but is not limited to interviews with patient/family, necessary staff and any pertinent witnesses. Nursing staff has been educated in writing on September 4<sup>th</sup>, 2014 on the expectation and necessity of verbal and written instructions regarding the grievance process to be given patients. This information will be given in new employee orientation as well. In addition, during social service routine interviews with residents, the Social Worker will ask the residents about their opportunity to voice any grievances. This will be documented in their notes.</p>	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/20/2014
NAME OF PROVIDER OR SUPPLIER  EASTERN IDAHO REGIONAL MEDICAL CENTER - TCU		STREET ADDRESS, CITY, STATE, ZIP CODE 3100 CHANNING WAY, 83404-7533 IDAHO FALLS, ID 83403		
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F 166	<p>Continued From page 8</p> <p>provide information regarding how the facility ensured prompt resolution to the residents' grievances, nor whether each item within the grievances were addressed, nor whether the resolution reached was acceptable to the resident.</p> <p>On 8/20/14 at 3:00 PM, the Administrator and DNS were informed of the surveyor's findings. On 8/20/14 at 1:30 PM, the facility faxed additional information. However, the information did not resolve the concerns</p> <p>F 225 SS=E 483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged</p>	F 166	<p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Starting on 16<sup>th</sup> of September 2014 on a weekly basis for 1 month, followed by monthly for 6 months, TCU Nurse Manager, Director or Clinical Team Lead will do a medical chart audit of 5 patients to verify inclusive documentation on grievance process that was given to the patient. Reeducation will be done if this documentation is absent.</p> <p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The grievance log has been updated. Every grievance received by TCU Social Worker, TCU Nurse Manger, or Director will be logged on the grievance log form and the original grievance form and investigation response will be kept in a grievance binder. Every grievance is investigated in a timely and thorough manner (see #3 and 4) with special focus on potential abuse/neglect.</p> <p>2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken? All residents may be affected.</p>	9/5/14

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F 225	<p>Continued From page 9</p> <p>violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on review of the facility's grievance file and staff interview, it was determined the facility failed to ensure all potential allegations of abuse and neglect were thoroughly investigated. This was true for 4 of 10 grievances reviewed in the facility's grievance file. The deficient practice had the potential for harm if a resident had been abused or neglected without the facility recognizing the situation and protecting the resident. Findings included:</p> <p>BFS Informational Letter 2014-04 documented types of situations which may indicate potential abuse or neglect have occurred and should be investigated and reported. The Informational Letter also documented Investigation Guidance, including: *Date and time of the incident; *A clear and legible description of exactly what occurred; *All pertinent staff, residents and other witnesses must be interviewed, and the results of the interview documented. Whenever possible,</p>	F 225	<p>3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? Twice each day, the Social Worker or Charge Nurse will check the inbox for new grievance forms. Upon receipt of the completed form, the Social Worker will notify the TCU Director or Nurse Manager within 2 hours. The Social Worker, Nurse Manager, Charge Nurse or Director will begin an investigation within 2 hours on weekday and 6 hours on weekend, of receipt of a completed grievance form. The investigation will include interviews with resident, staff and witnesses or other pertinent persons involved, and review of documentation. After a thorough investigation is completed by Social Worker, Nurse Manager, Charge Nurse or Director a resolution will be established. The TCU Director or Nurse Manager will report results and resolution to administration and resident with a mutually satisfactory resolution as the desired outcome.</p> <p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Starting 11<sup>th</sup> of September 2014, on a weekly basis for a month, then a monthly basis for a quarter, the Social Worker will meet with the TCU Director or Nurse Manager and discuss the outcomes/resolutions. Trends will be assessed and any necessary plan of correction implemented. A summary of the grievances and any identified patterns or trends will be reported in TCU Quarterly Meeting.</p>	

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F 225	Continued From page 10 witness statements should be signed. *Staff members accused of any potential abuse or neglect must be interviewed, and the interview must be documented. The accused staff member must be suspended until the investigation is complete, and may not be reassigned to another department in the facility or into a sister facility while the investigation is underway. *The resident involved must be interviewed.  The facility's grievance file documented: [NOTE: The dates listed are as documented in the facility's grievance file. It was unclear if they referred to month and day, or month and year.] **8-13. Complaint: Said 2 different days this week she was left on the commode for over 30 min. Had call light and people responded (i.e., someone at the nurse's station had used the intercom to ask what the resident needed, but did not physically come to the room) but no one came. Resolution: Spoke with charge nurse and DON and nurses were counseled on responding to call lights. Also instructed [patient] to push her call light again if her light is not answered by 10 minutes and inform the nurses that this is the second time she is calling." **1-13. Complaint: Family was upset about hearing a nurse talk about [patient] and other [patients] rudely. Requesting to never have that nurse again. Resolution: DON was notified and that nurse was counseled and [patient] was given other nurses." **4-14. Complaint: Family was upset with the way a particular nurse was physically handling patient. They felt she was being too rough. They also felt she was rude when talking to [patient]. They did not want her treating [patient] anymore. Resolution: Spoke with DON and this was discussed with that particular nurse."	F 225			

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F 225	<p>Continued From page 11</p> <p>**8/14. Complaint: Family upset that [patient's] pain has been under control and upset with a couple of nurses. Resolution: Met with [patient's] mother along with DON to discuss the complaints further...[Patient] had a better night last night and is doing better today. DON will talk with nurses regarding the complaints of the particular nurses."</p> <p>On 8/20/14, the SW was asked if the facility had a more thorough investigation of the above resident concerns. The SW stated the facility did not document all of the aspects of their investigation into the resident concerns. The SW stated the resolution of the concerns was generally a verbal exchange between herself, the Administrator, and the DON as needed. The SW stated she was confident none of the above allegations were allegations of abuse or neglect. The SW stated she had been present when one of the allegations was made and did not feel the situation was abusive.</p> <p>On 8/20/14 at 11:30 AM, the Administrator was asked about the facility's investigations when a resident alleged mistreatment. The Administrator stated when the reports were received, there was always a verbal exchange between herself, the SW, and the DON regarding the situation and a plan was developed to address the situation. The Administrator stated it was not felt any of the above instances were abuse or neglect, so were not investigated as such. The Administrator could not state for certain whether the above instances involved the same staff member. The Administrator stated she did not recall gathering statements from potential witnesses, interviewing the residents involved, or interviewing other residents receiving care from the accused staff.</p>	F 225		

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F 225	Continued From page 12 On 8/20/14 at 3:00 PM, the Administrator and DON were informed of the findings. The facility offered no further information.	F 225			
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY  The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.  This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, and staff interview, it was determined the facility failed to ensure residents were dressed per their preference, and had their hair combed. This was true for 2 of 7 residents (#s 3 and 7) sampled for resident dignity. The deficient practice had the potential for harm if residents became embarrassed when appearing in public in hospital gowns with unkempt hair.  1. Resident #7 was admitted to the facility on 7/23/14 with multiple diagnoses which included diabetes and intra-spinal abscess.  Resident #7's Admission MDS assessment, dated 8/4/14, coded the resident was cognitively intact, and required extensive assistance of one person for dressing and personal hygiene.  The resident did not have a care plan specific to dressing or hygiene.  On 8/19/14 at 10:45 AM, Resident #7 was observed in the therapy gym. She was seated in	F 241	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Staff received written education of the need to have each patient/resident given the opportunity to be dressed in their clothing of preference each day, and groomed upon leaving the room in addition to daily grooming. Every resident will be given the opportunity and encouraged to be dressed in their clothing of choice on a daily basis. They will be offered and encouraged to have their hair groomed prior to exiting the room for activity or therapy not only at the beginning of the day, but each time they exit the room if they appear unkempt.  2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken? All residents may be affected.	9/5/14	

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F 241	<p>Continued From page 13</p> <p>a wheelchair and was wearing a hospital gown with a cotton blanket over her lap. Her hair had not been combed, and had an oily sheen. Resident #1 backed up in her wheelchair to access an arm exercise machine. As she positioned herself to access the machine, the blanket became slightly askew on the left side of her lap, exposing her outer left thigh. The resident began to grasp at the blanket, in an effort to stretch it to cover her exposed skin.</p> <p>On 8/19/14 at 4:15 PM, Resident #7 was observed in her room in bed. Her hair appeared to have not been combed, and had an oily sheen. She was wearing a hospital gown. The resident stated she had completed her therapy, and would be discharging home in a few days. The resident was asked why she was not dressing daily, if she planned to discharge home so soon. The resident stated she had only one change of clothing, and since it had become soiled she had stopped dressing. The resident stated, "I'll have things at home I can wear when I get there." The resident reported she combed her own hair, when she felt it needed to be combed.</p> <p>2. Resident # 3 was admitted to the facility on 8/11/14 with multiple diagnoses which included debility, weakness, and multiple falls.</p> <p>An MDS had not yet been completed at the time of survey.</p> <p>On 8/19/14 at 8:00 AM, Resident #3, while lying in bed was served her breakfast meal. She was wearing a hospital gown, and her hair was unkempt.</p> <p>On 8/19/14 at 9:40 AM, Resident #3 was</p>	F 241	<p>3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? Patients will be interviewed by the MDS Coordinator. Interviews will include establishing clothing preference and that will be documented in the patient's plan of care. This preference will be updated during the residents stay on TCU as needed with changing status of resident. Nurses and therapists will give each resident the opportunity at least once daily to dress in the resident's clothing of choice and have their hair brushed/combed upon exiting the room in addition to normal daily grooming. On-going discussion and updates will be discussed during Weekly Team Meeting.</p> <p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? On a weekly frequency for 2 months, then a monthly basis for 3 months, TCU Nurse Manager, Director and/or Nurse Clinical Team Leads will perform an audit of 10 residents to ensure hair is groomed and they are wearing the clothing of their choice as recorded in the plan of care. This audit will be documented on an audit form. If resident is found to be unkempt and not in the clothing of their preference they will be assisted back to the room by appropriate staff and this task will be performed at that time.</p>	

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F 241	<p>Continued From page 14</p> <p>observed sitting in her wheelchair in the therapy gym, doing leg exercises. She was wearing 2 hospital gowns, one on frontward and one on backwards. Her hair was unkempt.</p> <p>On 8/19/14 at 9:55 AM, Resident #3 was again observed lying in bed and wearing 2 hospital gowns. The resident was asked if she was planning to get dressed for the day. The resident stated, "They didn't get me dressed today because I'm going to have a shower after lunch. I can get dressed after I have my shower."</p> <p>On 8/19/14 at 12:00 noon, the resident was observed sitting in the group room, eating her lunch. The resident now had three hospital gowns: one frontward, one backward, and a third draped over her shoulders. Her hair was disheveled.</p> <p>On 8/19/14 at 11:30 AM, the Administrator and MDS nurse were asked about resident observations of hospital gowns and unkempt hair. The MDS nurse stated many of the residents preferred to wear hospital gowns rather than regular clothes. However, the MDS nurse did not think this preference would be documented anywhere. The MDS nurse stated, "We ask the question on the MDS how important it is for the residents to choose their clothing, but I don't think we document other than that." The MDS nurse stated the residents' hair would be combed before breakfast.</p> <p>On 8/20/14 at 9:00 AM, OT #2 was asked about the facility's process for ensuring residents were dressed daily, in light of the facility's emphasis on rehabilitation. OT #2 stated, "We just talked about that this morning. We knew you were looking at</p>	F 241			

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F 241	Continued From page 15 that. My patient today is dressed. I don't know about some of the others, they may have refused."	F 241			
F 248 SS=E	On 8/20/14 at 3:00 PM, the Administrator and DNS were informed of the findings. The facility offered no further information. 483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES  The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.  This REQUIREMENT is not met as evidenced by: Based on staff interview, review of the facility activities calendar, and record review, it was determined the facility failed to identify and meet residents' leisure needs. The deficient practice had the potential to impact any resident wanting leisure activities or materials. The deficient practice had the potential to cause harm if residents experienced mood, behavioral, or cognitive changes when bored. Findings included:  1. Review of the facility Activities calendar for August 2014 revealed: *No activities listed on Saturdays or Sundays: *Each weekday listed only one activity per day. *Of the 21 days with activities listed: -"Walk to Dine" at noon was the only activity 11 days; -"X-Box games" was the only activity on 2 days; -"Movie during lunch" was the only activity on 3	F 248	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The activities calendar has been revised and updated. This calendar was delivered to each room and verbally introduced the residents/families.  2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken? Every patient/resident may be affected.	9/5/14	

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F 248	<p>Continued From page 16 days; -"Volunteer Individual Activities" was the only activity on 4 days; -"Craft/Cards" was the only activity on 1 day.</p> <p>On 8/19/14 at 11:30 AM, the Administrator and the MDS nurse were interviewed regarding the facility's activities program. They reported: *An activities assessment is done upon admission to the facility by the MDS nurse. *The activity assessment contained "about 15" probes to identify resident activity interests. *The results of that assessment are reviewed by the MDS nurse and OT #2, with the OT ultimately responsible to "sign off" on the assessment and plan. *Due to the nature of the resident population (short-stay rehabilitation), many of the residents preferred individual activities in their rooms, with a refusal rate for groups of approximately 80 percent. *Most residents' activities plans consisted of reading, television, and family visits. *The movie for the "Movie During Lunch" activity was selected by staff, without resident input. *The facility was aware the current activities program had some items which were not popular with the residents, so the facility planned to coordinate with "Volunteer Services" to try to meet resident leisure needs. *The MDS nurse was enrolled in an Activities Professional class to take place in September to become more knowledgeable regarding assessing and meeting resident leisure needs. *The MDS nurse provided a copy of the facility's assessment form. The probes to identify resident interests were: -Consideration of permanent physical impairments;</p>	F 248	<p>3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? 1 RN Staff member will participate in continuing education which will result in her being a certified activities director, in addition to our occupational therapist continual involvement. In addition, a resident specific form has been created. This form will be completed as a part of the activity director's initial interview and will include interests and interesting history of the individual resident. This form will kept in the patient's room and will be available for conversation for staff as they interact with the resident. It will also be used to plan/implement activities specific to the patient's history or interests.</p> <p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? On September 8<sup>th</sup>, 2014 an audit log was implemented to monitor appropriate resident satisfaction of their leisure time. On a weekly basis for 2 months, then monthly for 3 months, compliance will be established by checking a minimum of 5 patient/residents rooms for the presence of an activities calendar and interest form. This audit will be performed by the TCU Nurse Manager, Director or Clinical Team Lead. At this time, a verbal interview will be completed with the residents who are in their rooms to verify that they are aware of or have available to them activities to their satisfaction.</p>	

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NAME OF PROVIDER OR SUPPLIER  EASTERN IDAHO REGIONAL MEDICAL CENTER - TCU	STREET ADDRESS, CITY, STATE, ZIP CODE 3100 CHANNING WAY, 83404-7533 IDAHO FALLS, ID 83403
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F 248	<p>Continued From page 17</p> <ul style="list-style-type: none"> <li>-Consideration of temporary physical impairments;</li> <li>-Consideration of resident "behavioral problems";</li> <li>-Consideration of resident "neurological problems";</li> <li>-Visual and hearing aids required by the resident;</li> <li>-Individual and group activity pursuits;</li> <li>-Hobbies and interests;</li> <li>-Resident occupation, or prior occupation;</li> <li>-Resident desire to participate in groups;</li> <li>-Whether the resident is on bed rest or isolation precautions.</li> </ul> <p>On 8/20/14 at 9:00, OT #2 was interviewed regarding facility activities. OT #2 stated: *The facility's "certified activities person" had left approximately 2 months prior to the survey. The facility was planning to send the MDS nurse to a certification class, with OT #2 helping out in the meantime. *The facility tried to develop activities plans for the unique needs of their population, who were more acutely ill. OT #2 stated, "Some of them are difficult to convince them to come out for therapy, let alone come out for another activity." *OT #2 identified some activities which were popular with the residents, but not necessarily on the activities calendar. Examples included walking outside in the facility's garden, attending weekly performances by a harpist, and a reading cart which came around at least weekly. *The OT was asked about the facility's activities assessment form, and the emphasis on resident deficits rather than interests and abilities. The OT stated he was largely unaware of the specific probes on the form, so could not address that.</p> <p>On 8/20/14 at 11:00 AM, the MDS nurse provided a copy of an updated activities calendar for</p>	F 248		
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F 248	<p>Continued From page 18</p> <p>August 2014. The updated calendar documented the addition of:</p> <ul style="list-style-type: none"> <li>-Catholic Clergy and a book cart daily;</li> <li>-"Junior Volunteer and patient rounds" on Saturdays and Sundays;</li> <li>-Latter Day Saints services on Sundays;</li> <li>-A harpist in the evenings on Sundays and Wednesdays;</li> <li>-A "Pet Program" on Mondays, Wednesdays, and Thursdays.</li> </ul> <p>The MDS nurse stated these additional items had always been available, but had not been on the activities calendar previously. She was unable to state how residents would have known about the availability of those items prior to adding them to the calendar. The MDS nurse was unable to identify whether or not those activities were consistent with any interests identified by current residents. When asked, the MDS nurse could not state what other individualized activities, such as music for resident rooms, games, puzzle books, a list of available movies, etc., might be available to be offered to the residents.</p> <p>On 8/20/14 at 3:00 PM, the Administrator and DNS were informed of the findings. The facility offered no further information.</p>	F 248		
F 252 SS=E	<p>483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT</p> <p>The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.</p> <p>This REQUIREMENT is not met as evidenced</p>	F 252	<p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Every doorway and window frame of TCU was repaired and repainted. By September 13<sup>th</sup> the wallpaper seams will be repaired and the surfaces of the wallpaper will be cleaned and repaired.</p>	

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F 252	Continued From page 19 by: Based on observation and staff interview, it was determined the facility failed to ensure the resident living environment was clean and in good repair. This was true for 2 of 2 hallways, and 14 of 16 resident rooms (#s 600-613). The deficient practice had potential for harm if residents experienced a deterioration in their mood state from unpleasant surroundings. Findings included:  On 8/19/14 at 4:00 PM, the following observations were made of the resident environment: *Resident rooms 600-613 had multiple chips in the paint on the door frames, extending from the floor to the height of the door handle. Exposed bare metal could be seen where the paint was chipped. *The wallpaper below the handrails in the hallway was either torn, or coming apart at the seams between rooms 610 and 611, 612 and 613, 614 and 615, outside the therapy gym, and at the elevator. *The wallpaper was either dingy or faded between rooms 600 and 601, 604 and 605, and near the elevator.  On 8/20/14 at 10:20 AM, the Maintenance Director was asked about the above areas. The Maintenance Director stated he had been aware of the issues in that area of the facility, but had not addressed them yet in anticipation of a major remodeling project in that area.  On 8/20/14 at 3:00 PM, the Administrator and DNS were informed of the findings. The facility offered no further information.	F 252	2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken? Every resident may be affected.  3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? Daily Charge Nurse Rounds include assessment of general appearance of TCU. Additionally, once per quarter during environmental rounds an inspection will be completed to look for and document chips in paint and disrepair of the wallpaper across all hallways in the TCU. TCU Director, Nurse Manager, Charge Nurse or Engineering Department designee will complete this inspection and then request repair/repaint as needed.  4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? TCU Charge Nurse rounds daily for general inspection of appearance of TCU environment and logs this on her/his rounds form. In addition, once per month for a quarter, and then again in 3 months, the TCU Nurse Manager, Director or Clinical Team Lead will perform an inspection of the hallways, door frames and wallpaper of the main thoroughfare of the unit and at least 5 resident rooms. A tracking log will be completed to document the inspection and will be co-signed by engineering department designee.	9/5/14	
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323			

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F 323	<p>Continued From page 20</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure the resident environment was as free from hazards as possible. This was true for any resident needing access to the handrails in the hallway. The deficient practice had the potential to cause harm if a resident became unsteady and fell when the handrail was unavailable. Findings included:</p> <p>On 8/18/14 at 1:15 PM, during the initial tour of the facility, the following items were observed blocking access to the handrails in the hallway: *A vital signs machine, computer cart, and housekeeping cart between rooms 606 and 607. *A computer cart, wheelchair, and 2 vital signs machines between rooms 614 and 615. *A red crash cart outside the group room.</p> <p>The computer carts and crash cart were observed in the hallways blocking the handrail on 8/19/14 between 8:00 and 8:25 AM, 9:40 and 10:05 AM, and at 10:45 AM.</p> <p>On 8/19/14 at 4:00 PM, the following were observed blocking the handrails: *Between rooms 604 and 605, a wheelchair, wheeled computer cart, and vital signs machine.</p>	F 323	<ol style="list-style-type: none"> <li>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The hallways have been cleared of excessive equipment including unused nurse portable computers, nursing vital sign carts and crash cart. These items are wheels and can be easily moved as needed. They will be stored in a storage room unless in use and when not in use for more than 30 minutes will be returned to the storage room. The handrails are kept free from clutter. On September 8<sup>th</sup>, 2014 the staff received a written education on the storage area for the equipment. This will also be re-educated during staff meetings and TCU Quarterly meetings for 6 months.</li> <li>2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken? Every resident may be affected.</li> <li>3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? A storage place has been established for each piece of equipment that frequents the hallways and was previously at risk for remaining stationary for greater than 30 minutes. Education will also be included in the new employee orientation in regards to the importance of clutter free hallways and appropriate storage places for equipment.</li> </ol>	9/5/14
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F 323	Continued From page 21 *Between rooms 606 and 607, a wheeled computer cart. *Between rooms 612 and 613, a wheeled computer cart and a vital signs machine. *Between rooms 613 and 614, a wheeled computer cart. *Between the nurse's station and the group room, the red crash cart. 2 utility carts, and an enclosed meal tray cart. During the above observation, all of the wheeled computers and vital signs machines were plugged in to outlets along the wall.  On 8/20/14 at 8:25 AM, the Administrator was asked about the equipment stored in the hallway. The Administrator stated the facility thought it was acceptable to store the equipment on just one side of the hallway, leaving access to handrails on the other side. However, that did not address the concern for a resident who may only be able to use one side of their body, or residents who may be ambulating on the side of the hallway where the handrails were blocked.  On 8/20/14 at 3:00 PM, the Administrator and DNS were informed of the findings. The facility offered no further information.	F 323	4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The TCU Nurse Manager, Director or Clinical Team Lead will perform hallway monitoring daily for a month, then weekly for a month, then monthly for 3 months to establish compliance. A log will be maintained of these compliance audits. TCU Nurse Manager or Director will educate individual staff members found to be non-compliant.		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS  Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any 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	F 329	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #5 had his duplicate anti-psychotic medication discontinued 8-19-14. He has also been D/C'd from the facility. Resident #1 did not have any doses of Geodon administered and this medication was discontinued on 8-18-14. Nursing staff has received verbal and written education so this would not reoccur.	9/5/14	

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F 329	<p>Continued From page 22</p> <p>combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility failed to ensure residents were free from unnecessary antipsychotic medications. This was true for 2 of 2 residents (#s 1 and 5) sampled for antipsychotic medication use. The deficient practice had the potential to cause harm if residents experienced adverse effects from the use of these medications. Findings included:</p> <p>1. Resident #5 was admitted to the facility on 8/14/14 with a primary diagnosis of acute cholecystitis.</p> <p>Resident #5 had not yet had an MDS completed at the time the survey was conducted.</p> <p>Resident #5's History and Physical, dated 8/5/14, documented a list of medications the resident</p>	F 329	<p>2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken? Every resident may be affected.</p>		

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F 329	<p>Continued From page 23</p> <p>was taking at that time. There were no antipsychotic medications documented on that list.</p> <p>Resident #5's medication orders upon admission to the facility included the antipsychotic Olanzapine (Zyprexa) 2.5 mg daily at bedtime. No diagnosis was listed for this medication.</p> <p>On 8/16/14, Resident #5's Plan of Care - Initial form did not document the use of an antipsychotic medication, target behavioral symptoms, how the target behavioral symptoms were harmful to the resident or others, non-pharmacological interventions, expected outcomes, or that the resident should be monitored for adverse reactions to the medication.</p> <p>On 8/17/14 at 7:42 PM, a physician's progress note for Resident #5 documented, "Chief complaint: Intermittent confusion...I was called to see the patient with regards to confusion and agitation which has definitely been worse at night...at the time of my interview and examination of him, he does appear mildly agitated, but his statements were actually fairly appropriate...Assessment/Plan...delirium - consistent with 'Sundowner's syndrome,' however cannot rule out early developing infection..."</p> <p>On 8/17/14 at 9:00 PM, a physician's order for Resident #5 documented the addition of Seroquel 25 mg daily at bedtime, with a diagnosis of dementia related psychosis. This was the only documentation in Resident #5's record of a diagnosis of dementia. No changes to the Plan of Care - Initial form were documented regarding the addition of this medication change.</p>	F 329	<p>3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? Antipsychotic medication may be Indicated when other causes for, extreme restlessness, uncontrollable or excessive body movements, purposeless restless activity, pacing, and crying has been ruled out. These symptoms place the resident at risk for falls, poor nutrition, and difficulty sleeping. The expected outcome for these residents would be a decrease in fall risk, proper nutrition, and improved sleeping. Prior to admission to TCU, all patients who currently have anti-psychotic medication orders or behavioral issues will be identified by the intake coordinator. The activities director will promptly be made aware of the admission of these patients. The activities director will perform an activity assessment within 1 business day of admission to identify and care plan alternative non-pharmacological interventions. Nursing staff was verbally educated immediately and have been educated again in writing regarding appropriate use of non-pharmacological interventions. These interventions are to be used prior to medication therapy. In addition, staff will receive reinforcement of this education at September Staff Meeting. This education will also be completed during new employee orientation with all licensed nursing staff.</p>	

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F 329	Continued From page 24  On 8/19/14 at 9:40 AM, the resident's representative stated the resident had been admitted to the facility following "gallbladder surgery" and had a difficult time recovering from the anesthetic. The resident's representative stated the facility had started the resident on a "sleeping pill" two nights ago, and was hopeful the resident would show improvement. The resident's representative was not sure of the exact medication the facility had started, and was not aware of any concerns with the use of either medication for the resident.  On 8/19/14 at 11:10 AM, the DNS was asked about the use of antipsychotic medications for Resident #5. The DNS stated the resident had been admitted on Zyprexa, but the facility was still in the evaluation process for that medication due to the resident's recent admission. The DNS was uncertain at that point why the resident was receiving Zyprexa. The DNS stated the resident had been started on Seroquel for dementia-induced psychosis, with confusion and hallucinations in the evenings. The DNS was unable to describe the nature of the resident's hallucinations, or how those hallucinations were harmful to the resident or others. The DNS could not state if the hallucinations were persistent. The DNS stated typically the facility's standard non-pharmacological interventions prior to starting an antipsychotic medication were toileting, pain management, and placing a sitter with the resident. The DNS could not state for sure these interventions had been attempted with Resident #5, nor if those interventions had been evaluated to be appropriate for his individual needs. The DNS could not state why the resident required two different antipsychotic medications,	F 329	The pharmacist upon weekly review of medications will assist in monitoring for adverse reactions. All nursing staff has been educated and has access to the adverse reactions of antipsychotics in Clinical Pharmacology on the Intranet. The suggested list of these interventions, as well as a list of anti-psychotic medications, has been made easily accessible to nurses on the unit for reference.  4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Every residents chart will be audited for new anti-psychotic medications to verify that the appropriate non-pharmacological interventions were completed with the resident and documented prior to new anti-psychotic medicine being delivered. This audit started 9/19/14 and will be weekly for 2 months, and then monthly on an ongoing basis by TCU Nurse Manager, Clinical Team Lead or Director.		

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F 329	<p>Continued From page 25</p> <p>nor whether potential adverse effects were being monitored. The DNS could not identify a specific target behavior.</p> <p>On 8/19/14 at 11:25 AM, the DNS provided documentation from the resident's record that a "Behavioral/Emotional Monitor" had been initiated on 8/18/14, the day after the Seroquel was started. The monitor did not document any behaviors for, "Patient voicing distress by...", "Sleep cycle issues," "Sad, apathetic, anxious appearance," and, "loss of interest." Additionally, the form did not document a specific target behavior related to Zyprexa or Seroquel use.</p> <p>On 8/19/14 at 1:00 PM, the Pharmacist was asked about the resident's new order for Seroquel and the justification for the resident to use 2 antipsychotic medications. The Pharmacist stated there was a pharmacy review for each resident weekly, but the resident had not been in the facility long enough to have his medications reviewed. The Pharmacist stated the resident's medications would be reviewed the next day, and if it was felt any of the medications were unnecessary, a recommendation would be made to the physician at that time.</p> <p>On 8/19/14 at 5:00 PM, the Administrator and DNS were informed of the findings. The facility offered no further information.</p> <p>2. Resident #1 was admitted to the facility on</p>	F 329			

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F 329	<p>Continued From page 26</p> <p>8/5/14 with multiple diagnoses which included UTI (Urinary Tract Infection), Sepsis, Sacral Decubitus Ulcer, and Osteomyelitis Stage IV Ulcer.</p> <p>Resident #1 had not yet had an MDS completed at the time the survey was conducted.</p> <p>Review of the resident's medical record included documentation that on 8/14/14 at 5:25 PM a physician was notified of the following situation, "Patient increasingly confused, anxious, restless, hallucinating, seeing children in room that are not there. Husband left felt like he was causing her more anxiety by being there. He asked that we give her something to calm her down." The Comments/Physician's response section documented, "I will put some orders in the computer."</p> <p>Record review of the resident's medication list (e-MAR Administration Report), documented an order for an antipsychotic, Geodon 10 mg, IM (intramuscular), once, PRN for agitation or anxiety with a start date of 8/16/14.</p> <p>On 8/20/14 at 9:50 AM, the surveyor interviewed the TCU Manager regarding the order for Geodon, an antipsychotic medication, for the husband's request of "something to calm her down." The TCU Manager stated the resident had never been given the medication and that it should have been discontinued as the original order documented a stop date of 8/18/14. The surveyor showed the resident's e-Mar Administration Report, with a run date of 8/19/14, which showed the Geodon medication still on the report. The surveyor made the TCU Manager aware of the potential for the resident to be</p>	F 329			

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NAME OF PROVIDER OR SUPPLIER  EASTERN IDAHO REGIONAL MEDICAL CENTER - TCU			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 CHANNING WAY, 83404-7533 IDAHO FALLS, ID 83403		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 329	Continued From page 27 placed on an antipsychotic, an unnecessary medication, when the husband had only requested something to calm her down. The TCU Manager stated, "Yes, that is a concern."  On 8/20/14 at 3:00 PM, the Administrator and TCU Manager were made aware of the concern regarding the potential for a resident to receive an antipsychotic medication PRN for the reason of agitation or anxiety. No further information was provided by the facility which resolved the issue.	F 329			

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  MDS001180	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED  08/20/2014
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NAME OF PROVIDER OR SUPPLIER  EASTERN IDAHO REGIONAL MEDICAL CENTE	STREET ADDRESS, CITY, STATE, ZIP CODE 3100 CHANNING WAY, 83404-7533 IDAHO FALLS, ID 83403
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C 000	16.03.02 INITIAL COMMENTS  The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2. The following deficiencies were cited during the federal re-certification and state licensure survey of your facility.  The surveyors conducting the survey were: Rebecca Thomas, RN, Team Coordinator and Nina Sanderson, BSW, LSW	C 000		
C 117	02.100,03,c,i Fully Informed of Rights  i. Is fully informed, as evidenced by the patient's/resident's written acknowledgement, prior to or at the time of admission and during his stay, of these rights and of all rules, regulations and minimum standards governing patient/resident conduct and responsibilities. Should the patient/resident be medically or legally unable to understand these rights, the patient's/resident's guardian or responsible person (not an employee of the facility) has been informed on the patient's/resident's behalf; This Rule is not met as evidenced by: Please see F 156 as it pertains to the facility's Admission Agreement.	C 117	PLEASE REFER TO F 156	9/5/14
C 119	02.100,03,c,iii Informed of Medical Condition by Physician  iii. Is fully informed, by a	C 119	PLEASE REFER TO F154	9/5/14

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OCT 31 2014  
FACILITY STANDARDS

Bureau of Facility Standards LABORATORY DIRECTOR'S FOR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE NHA	(X6) DATE 9/29/10
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Bureau of Facility Standards

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C 119	Continued From page 1.  physician, of his medical condition unless medically contraindicated (as documented, by a physician, in his medical record), and is afforded the opportunity to participate in the planning of his medical treatment and to refuse to participate in experimental research; This Rule is not met as evidenced by: Please see F 154 as it pertains to resident or family notification of medical condition.	C 119		
C 121	02.100,03,c,v Encouraged/Assisted to Exercise Rights  v. Is encouraged and assisted, throughout his period of stay, to exercise his rights as a patient/resident and as a citizen, and to this end may voice grievances and recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal; This Rule is not met as evidenced by: Please see F166 as it pertains to grievances.	C 121	PLEASE REFER TO F166	9/5/14
C 125	02.100,03,c,ix Treated with Respect/Dignity  ix. Is treated with consideration, respect and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; This Rule is not met as evidenced by: Please see F 241 as it pertains to resident dignity.	C 125	PLEASE REFER TO F241	9/5/14

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C 147	Continued From page 2-	C 147		
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: Please see F 329 as it pertains to antipsychotic use in the facility.	C 147	PLEASE REFER TO F329	9/5/14
C 175	02.100,12,f Immediate Investigation of Incident/Injury  f. Immediate investigation of the cause of the incident or accident shall be instituted by the facility administrator and any corrective measures indicated shall be adopted. This Rule is not met as evidenced by: Please see F 225 as it pertains to investigations of resident concerns.	C 175	PLEASE REFER TO F225	9/5/14
C 295	02.107,04,d Current Diet Manual  d. A current diet manual approved by the Department and the patient's/resident's physician shall be available in the kitchen and at each nursing station (the Idaho Diet Manual is approved by the Department). This Rule is not met as evidenced by:	C 295	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Training has been provided to nurses of TCU regarding electronic access of the diet manual. Training included written and verbal step-by-step instructions on electronic access to the diet manual present on computers, as well as an established competency.	9/5/14

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C 295	<p>Continued From page 3.</p> <p>Based on observation and staff interview, it was determined the facility failed to ensure a diet manual was located and available for use at the unit's nurses station. This affected 7 (#s 1-7) sampled residents and had the potential to affect all residents who resided in the facility. Findings included:</p> <p>On 8/19/14 at 12:00 PM, the surveyor asked for the unit nurses station copy of the diet manual. LN #1 and the TCU Manager/DON could not locate the diet manual on the nurses station. The TCU Manager then looked in the Group Room but was unable to locate the diet manual. The TCU Manager then suggested the diet manual could be accessed electronically. LN #1 tried without success to access the diet manual from his computer terminal at the nurses station.</p> <p>On 8/19/14 at 12:20 PM, the RD (Registered Dietician) told the surveyor the dietary manual was accessible on the computer terminal at the nurses station. The RD then provided step by step instructions to LN #1 who was then able to access the diet manual. The RD stated to the surveyor that all the nurses had been in-serviced on how to access the diet manual. The surveyor asked the RD to supply a copy of the content of that in-service along with the signature sheet of who had received it. At 12:25 PM, the RD supplied a copy of the Information Resource Guide which included "clinical resources-E-library" which listed multiple resources, including the Nutrition Care Manual. However, the information provided did not include a signature sheet of who received the in-service.</p> <p>On 8/19/14 at 2:05 PM, LN #1 stated to the surveyor, he "used to be able to access the diet manual on the Intranet, but we can't do that</p>	C 295	<ol style="list-style-type: none"> <li>2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken? All residents on TCU have potential to be affected.</li> <li>3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? This information will be reviewed in the next 2 monthly staffing meetings. Training will be completed in the new employee orientation to ensure that the new staff members coming on will have this same training/information.</li> <li>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? TCU Director, Nurse Manager or Clinical Team Lead will audit staff fluency in electronically accessing the diet manual once weekly for 4 weeks and then then once per month for 2 months. Audits started 9-9-14.</li> </ol>	
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Bureau of Facility Standards

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C 295	Continued From page 4.  anymore. The RD rounds on patients and supplies that information."  On 8/19/14 at 5:05 PM, the Administrator and the facility Manager/DON were made aware of the concern with facility nurses being aware of the diet manual and how to access it electronically. No further information was provided by the facility.	C 295		
C 362	02.108,07,a Interior Surfaces Kept Clean & Sanitary  a. Floors, walls, ceilings, and other interior surfaces, equipment and furnishing shall be kept clean, and shall be cleaned in a sanitary manner. This Rule is not met as evidenced by: Please see F 252 as it pertains to the condition of the facility's door frames and wallpaper.	C 362	PLEASE REFER TO F252	9/5/14
C 519	02.121,06,a PATIENT/RESIDENT DINING & RECREATION  06. Patient/Resident Dining and Recreation Areas. The following minimum requirements apply to dining/recreation areas.  a. Area requirement. The total area set aside for these purposes shall be at least thirty (30) square feet per bed with a minimum, total area of at least two hundred twenty-five (225) square feet. For facilities with more than one hundred (100) beds, the minimum area may be reduced to twenty five (25) square	C 519	We are requesting a waiver of the Square footage requirement as set by The Bureau of Facility Standards for our facility's dining room. It is my understanding that according to these standards, our dining room is thirty-seven (37) square feet smaller than required. Upon recent observation by surveyors this was not found to compromise the residents' dining experience.	

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C 519	<p>Continued From page 5.</p> <p>feet per bed. If day care programs are offered, additional space shall be provided as needed to accommodate for day care patients/residents needing naps or for dining and activities. This Rule is not met as evidenced by: Based on observation, review of a previous room size waiver, and staff interview, it was determined the facility did not ensure the TCU (Transitional Care Unit) dining/recreation room complied with state regulation, the dining room must contain 30 square feet per bed. This was true for 7 of 7 (#s 1-7) sampled residents and had the potential for residents to not participate in recreational activities or eat in the dining room should the dining/recreation room become too crowded. Findings include:</p> <p>During the initial tour of the facility on 8/18/14 at 1:15 PM, it was observed the dining/recreation room in the TCU did not meet the minimum requirements. Specifically, the area measured 443 square feet, instead of the required 480 square feet.</p> <p>During the survey process, a total of three different residents were observed dining in the dining/recreation area.</p> <p>On 8/12/14 at 11:40 AM, the Administrator was asked if the facility would continue to request a waiver of the dining/recreation room size. The Administrator stated, "Yes, we want to request a waiver."</p> <p>The surveyors found the decreased space did not compromise residents' dining/recreation experience. The request for a waiver renewal for this requirement should be included in the facility's Plan of Correction.</p>	C 519		
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C 666	<p>02.150,02,c Quarterly Committee Meetings</p> <p>c. Meet as a group no less often than quarterly with documented minutes of meetings maintained showing members present, business addressed and signed and dated by the chairperson. This Rule is not met as evidenced by: Based on review of the Infection Control Meeting Minutes and staff interview, it was determined the facility failed to ensure a representative from each department was included and signed in at the Infection Control Meetings. This failure had the potential to affect all residents, staff and visitors to the facility. Findings included:</p> <p>The Infection Control Protocol was reviewed on 8/20/14 at 10:00 AM with the Director of Quality Management and the TCU Manager. The Director of Quality Management provided the sign in sheet from the Quarterly Infection Control Meetings. Upon review of the sign-in sheets, it was determined following departments were not represented: *Pharmacy and Maintenance for the December 2013 meeting; *TCU and Maintenance for the May 2014 meeting; and, *Maintenance for the July 2014 meeting.</p> <p>On 8/20/14 at 11:20 AM the TCU Manager stated she was on vacation during the May 2014 meeting. When asked why someone from the department had not gone in her place, the TCU Manager stated, "Yes, I can see someone should have gone."</p> <p>On 8/20/14 at 3:00 PM, the Administrator and TCU Manager were made aware of the above concern. No further information was provided by</p>	C 666	<ol style="list-style-type: none"> <li>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? All residents except for #1 &amp; #7 have been discharged from the facility. We are unable to resolve this for these 2 residents due to these meetings having occurred in the past.</li> <li>2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken? Every resident has the potential to be affected.</li> <li>3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? Meetings will be set up and initially communicated with the full group of invitees, including the mandatory persons. A reminder message will be sent. Absent mandatory attendees will be required to have a designee present in their place. On the attendee sign-in list of the Quarterly Infection Control Meeting, mandatory attendees will be identified. If required attendees or their designee are absent, the information will be covered again at TCU Quarterly Meeting.</li> <li>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Every other month, after each Infection Control meeting, a list of mandatory attendees will be reviewed by the TCU Nurse Manager, Director or Clinical Team Lead for attendance compliance. Absence of any of the mandatory members or their designee will be noted and the information will be covered at the subsequent TCU quarterly meeting in their presence. This person's presence, or their designee, at the TCU Quarterly meeting will be verified by the signature page and noted on audit form.</li> </ol>	9/5/14

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C 666	Continued From page 7 the facility which resolved the issue.	C 666		
C 674	02.151,01 ACTIVITIES PROGRAM  151. ACTIVITIES PROGRAM.  01. Organized Program. There shall be an organized and supervised activity program appropriate to the needs and interests of each patient/resident. The program shall be designed to include a variety of processes and services which are designed to stimulate patients/residents to greater self-sufficiency, resumption of normal activities and maintenance of an optimal level of psychosocial functioning. It shall include recreation, therapeutic, leisure and religious activities. This Rule is not met as evidenced by: Please see F 248 as it pertains to the facility's activities program.	C 674	PLEASE REFER TO F248	9/5/14
C 790	02.200,03,b,vi Protection from Injury/Accidents  vi. Protection from accident or injury; This Rule is not met as evidenced by: Please see F 323 as it pertains to environmental hazards.	C 790	PLEASE REFER TO F323	9/5/14