



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 3050 0001 2125 6157

September 10, 2014

Michael E. Borup, Administrator
Quinn Meadows Rehabilitation & Care Center
1033 West Quinn Road,
Pocatello, ID 83202-2425

Provider #: 135136

Dear Mr. Borup:

On **August 27, 2014**, a Complaint Investigation survey was conducted at Quinn Meadows Rehabilitation & Care Center 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 23, 2014**. Failure to submit an acceptable PoC by **September 23, 2014**, may result in the imposition of civil monetary penalties by **October 14, 2014**.

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

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

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

Michael E. Borup, Administrator
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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 **October 1, 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 **October 1, 2014**. A change in the seriousness of the deficiencies on **October 1, 2014**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **October 1, 2014** includes the following:

Denial of payment for new admissions effective **November 27, 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 27, 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 Office or the State Medicaid Agency beginning on **August 27, 2014** and continue until substantial

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

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

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

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

- BFS Letters (06/30/11)

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

[2001-10 IDR Request Form](#)

This request must be received by **September 23, 2014**. If your request for informal dispute resolution is received after **September 23, 2014**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,



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

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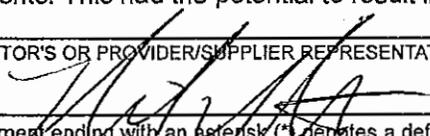
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135136	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/27/2014
NAME OF PROVIDER OR SUPPLIER QUINN MEADOWS REHABILITATION & CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1033 WEST QUINN ROAD POCATELLO, ID 83202	
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F 000	INITIAL COMMENTS The following deficiencies were cited during a Complaint Survey at your facility. The survey team included: Susan Gollobit, RN, team coordinator Amy Barkley, RN, BSN The survey team entered the facility on 8/27/14 and exited the facility on 8/27/14. Survey Definitions: ALF = Assisted Living Facility DON = Director of Nursing LN = Licensed Nurse LTC = Long Term Care O.T. = Occupational Therapy P.O. = Physician's Orders	F 000	<i>Preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the accuracy or truthfulness of any facts alleged or any conclusions set forth in this allegation of deficiencies by the State Licensing Authority. Accordingly, the facility has drafted this Plan of Correction in accordance with Federal and State Laws which mandate the submission of a Plan of Correction as a condition for participation in the Medicare and Medicaid program. This Plan of Correction shall constitute this facility's credible allegation compliance with this section.</i>	
F 283 SS=E	483.20(I)(1)&(2) ANTICIPATE DISCHARGE: RECAP STAY/FINAL STATUS When the facility anticipates discharge a resident must have a discharge summary that includes a recapitulation of the resident's stay; and a final summary of the resident's status to include items in paragraph (b)(2) of this section, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or legal representative. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review it was determined the facility failed to document a complete recapitulation of stay at the time of discharge for 4 of 4 (#1, 2, 3, 4) sampled residents. This had the potential to result in	F 283	F- 283 SS=E §483.20 (I) (1) & (2) - Anticipate Discharge: RECAP STAY/FINAL STATUS The facility does ensure to document a complete recapitulation of stay on Residents that are discharging from the facility. Corrective action(s) accomplished for those residents found to have been affected by the deficient practice: Resident # 1, 2, 3, & 4 are no longer a Resident of the facility.	10/01/14

RECEIVED
SEP 18 2014
FACILITY STANDARDS

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

TITLE

(X6) DATE



Administrator 9/17/14

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

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F 283	<p>Continued From page 1</p> <p>inappropriate discharge planning and/or a lack of needed information to ensure the continuance of care once the resident left the facility. Findings included:</p> <p>1. Resident #1 was admitted to the facility on 3/18/14 and was discharged on 4/17/14. The resident had diagnoses that included care involving use of rehabilitation procedures, unspecified mood disorder and mild mental retardation.</p> <p>The resident's Interdisciplinary Discharge Summary, which included instructions to complete upon discharge and address all items documented:</p> <p>*Recapitulation of Resident's Stay, -Admission and Discharge dates were both blank. -Reason for admission was blank.</p> <p>*Final Summary of the Resident's Status, -Social Service section was signed on 4/15/14. The section for personal belongings sent with resident, with family or other was not completed. -Nursing Service section was signed on 4/17/14. This section had blank areas for clinical lab values or diagnostic tests, and drug therapy required. -Dietary service section was blank. -Activities section was blank. -Rehab(ilitation) services was completed on 4/15/14.</p> <p>*Attending Physician and record no. (number) was not documented on the Reapitulation of Resident's Stay form.</p> <p>2. Resident # 3 was admitted to the facility on 7/16/14 and was discharged on 7/31/14. The</p>	F 283	<p>Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken includes the following:</p> <p>All Residents who will be discharging from the facility may have the potential to be affected by this deficiency. Hence, to address residents who may have the potential to be affected by this deficiency, by 09/26/2014 the Administrator or Director of Nurses or his/her designee will provide an in-service education to the Social Services Director, LN Unit Managers, Dietary Director, Activity Director, and the Occupational Therapists identified during the survey process with regards to the importance of the completion of their section in the "Interdisciplinary Discharge Summary," on Residents that are discharging from the facility.</p> <p>Measures that will be put into place or systemic changes you will make to ensure that the deficient practice does not recur includes the following:</p> <p>To ensure that the deficient practice does not recur,</p> <p>An " Interdisciplinary Discharge Summary Completion Checklist," will be developed by the Director of Nurses or his/her designee by 09/25/2014, for the Interdisciplinary Discharge Team to utilize starting on 09/29/2014, to ensure completion of their department section on Residents that are discharging from the facility.</p>		

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F 283	<p>Continued From page 2</p> <p>resident had diagnoses that included care involving use of rehabilitation procedures, other and unspecified intra cranial hemorrhage.</p> <p>The resident's Interdisciplinary Discharge Summary, documented: *Recapitulation of Resident's Stay, -Discharge date was blank.</p> <p>*Final Summary of the Resident's Status, -Social Service section was signed on 7/24/14. The section for personal belongings sent with resident, with family or other was not completed. -Nursing Service section was signed on 7/31/14. The clinical lab values or diagnostic tests was blank. -Dietary service section was blank. -Activities section was blank. -Rehab services was completed on 7/24/14.</p> <p>On 8/27/14 at 2:15-PM, the Administrator, DON and Social Worker were informed of the findings. No additional information was provided.</p> <p>3. Resident #2 was admitted to the facility on 5/12/14 and discharged on 5/28/14 with multiple diagnoses to include right hip fracture, diabetes mellitus type 2, and hypertension.</p> <p>The resident's Interdisciplinary Discharge Summary dated 5/28/14 documented: * Recapitulation of Resident's Stay: - The reason for admission was left blank. - Treatment provided by Occupational Therapy to include progress and reason for discharge was incomplete.</p> <p>* Final Summary of the Resident's Status: - Social Service section was signed on 5/24/14.</p>	F 283	<p>The facility Administrator or Director of Nurses or his/her designee, by 09/26/2014, will in-service the Interdisciplinary Discharge Team, with regards to F-283, with emphasis on:</p> <ul style="list-style-type: none"> The importance of the Interdisciplinary Discharge Team making sure, that using the "Interdisciplinary Discharge Summary Completion Checklist" as a tool; their departments complete their specific sections in the "Interdisciplinary Discharge Summary," <p><i>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</i></p> <p>Monitoring will be done through:</p> <p>The Director of Nurses or his/her designee will review at least 3 discharges to ensure completion of the "Interdisciplinary Discharge Summary," on Residents that are discharging from the facility.</p> <p>Monitoring will start on 10/01/2014 This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3.</p> <p>The facility Director of Nursing or his/her designee will submit to the Administrator or his/her designee and to the QA&A Committee her findings and/or corrective actions taken during the quarterly QA&A Committee Meeting.</p>	<p><i>Administrators</i> <i>10/3/14</i> <i>started at 1:50pm</i> <i>sent 3 discharges</i> <i>per monitoring</i> <i>Case</i></p>

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

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F 283	Continued From page 3 The section for personal belongings sent, "with resident, with family, or other" was blank. - Nursing Services section was signed on 5/28/14. Clinical values or diagnostic test was blank. The special treatments or procedures planned for discharge did not identify O.T. was needed. Drug therapy required and disposition of medications was left blank. - Dietary Services section was blank. 4. Resident #4 was admitted to the facility on 4/29/14 and discharged on 5/19/14 with multiple diagnoses to include small bowel obstruction, hypertension, depression, and osteoporosis. The resident's Interdisciplinary Discharge Summary dated 5/28/14 documented: * Recapitulation of Resident's stay: - The discharge date was blank. * Final Summary of Resident's Stay: - Social Service section was signed on 5/15/14. The section for personal belongings sent, "with resident, with family, or other" was blank. - Nursing Services, Dietary Services, and Activities all blank. On 8/27/14 at 2:15 PM, the Administrator, DON and Social Worker were informed of the findings. No additional information was provided. Refer to F284 as it relates to inadequate discharge planning.	F 283	Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee quarterly meeting.		
F 284 SS=E	483.20(l)(3) ANTICIPATE DISCHARGE: POST-DISCHARGE PLAN When the facility anticipates discharge a resident must have a discharge summary that includes a	F 284			

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F 284	<p>Continued From page 4</p> <p>post-discharge plan of care that is developed with the participation of the resident and his or her family, which will assist the resident to adjust to his or her new living environment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review it was determined the facility failed to document a complete and accurate discharge plan for 4 (#1, 2, 3, 4) of 4 sampled residents. The deficient practice caused the potential for harm as the discharge plans did not document the services the residents would need or be provided after discharge from the facility. Findings included:</p> <p>1. Resident # 3 was admitted to the facility on 7/16/14 and was discharged on 7/31/14. The resident had diagnoses that included care involving use of rehabilitation procedures, other and unspecified intra cranial hemorrhage.</p> <p>The resident's Home Health referral form which was not dated or signed, documented: *Please provide the following home health services: -Nurse for: "teaching, assessment monitoring observation". -OT (Occupational Therapy) for : "The pt. [patient] still requires Min[imal] [assist] for safe transfers/ambulation".</p> <p>*List the Diagnosis/Clinical findings to support the need for home health services: -"The pt. fell resulting in intracranial hemorrhage, poor balance, weakness. She is currently a high fall risk and requires Min [assist] [with] transfer, ambulation, and ADL's [activities of daily living] for</p>	F 284	<p>F- 284 SS=E §483.20 (I) (3) - Anticipate Discharge: POST DISCHARGE PLAN</p> <p>The facility does anticipate discharge and ensures that each resident has a discharge summary that includes a post-discharge plan of care</p> <p>Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:</p> <p>Resident # 1, 2, 3, & 4 are no longer a Resident of the facility.</p> <p>Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken includes the following:</p> <p>All Residents who will be discharging from the facility may have the potential to be affected by this deficiency. Hence, to address residents who may have the potential to be affected by this deficiency, by 09/26/2014 the Administrator or Director of Nurses or his/her designee will provide an in-service education to the Social Services Director, LN Unit Managers, Dietary Director, Activity Director, and the Occupational Therapists identified during the survey process with regards to the importance of ensuring that applicable discharge forms are filled out completely and accurately.</p>	10/01/14
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F 284	<p>Continued From page 5 safety."</p> <p>*I certify that the patient is homebound due to: -"The pt. demonstrates low endurance and requires Min [assist] for safety [with] transfers and ambulation.</p> <p>*I certify that this patient is under my care and I have had a face to face encounter that meets the Medicare requirements: A hand written note which stated "sign" was documented under this statement with no signature and a line for the date was left blank.</p> <p>On the bottom of the form were lines for a physician signature, time and date, which were blank. A hand written note which stated "sign" was documented beside the lines.</p> <p>The resident's discharge form which documented home care and discharge instructions, was signed by the resident but not dated, was signed by the Physician and dated 7/30/14 and was signed by a LN (Licensed Nurse) and dated 7/31/14, documented:</p> <p>*Patient Name: Had resident's last name spelled inaccurately. *Discharge to: "Home" *Diet: "Regular" *Home Health: This section was to document the name of the Home Health service to provide the cares, and was blank. *The form had 4 sections which included boxes to check for Home Health services to be provided, none of the boxes were marked. *Weight bearing instructions: __as tolerated _____. Was blank. *Discharge Labs to be done: Was Blank.</p>	F 284	<p>Measures that will be put into place or systemic changes you will make to ensure that the deficient practice does not recur includes the following:</p> <p>To ensure that the deficient practice does not recur,</p> <p>By 09/25/2014, A "Discharge Checklist," will be developed by the Director of Nurses or his/her designee. This is designed to be used starting on 09/29/2014, as a tool by the Interdisciplinary Discharge Team for each anticipated discharge, to ensure that applicable discharge forms which will need to be filled out by their department prior to or at the time the residents' discharge are complete and accurate.</p> <p>The Administrator or Director of Nurses or his/her designee by 09/26/2014, will in-service the Interdisciplinary Discharge Team with regards to F-284, on the following:</p> <ul style="list-style-type: none"> The Interdisciplinary Team using the "Discharge Checklist," as a tool for each anticipated discharge to ensure that applicable discharge forms which will need to be filled out by their department prior to or at the time the residents' discharge are complete and accurate. 	
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F 284	<p>Continued From page 6</p> <p>*Follow up appointments: Was blank.</p> <p>*Discharge Medications: There were 11 home medications documented.</p> <p>On 8/27/14 at 10:45 AM, the surveyor asked the Social Worker (SW) if she was the person designated to set up Home Health for the residents when they discharged from the facility. The SW stated she was. When asked if the resident had Home Health provided to her when she was discharged per the recommendation of the Home Health referral form, the SW stated, "I am not sure." When asked who filled out the OT referral on the form, the SW stated, "The PT is the one who fills it out." When asked who had filled out the nursing referral section of the form, the SW stated, "I am not sure." The surveyor asked what the process was to provide Home Health for residents when they were discharged. The SW stated, "This form (Home Health referral form), with the discharge orders, history and physical and the resident's face sheet is sent to the Home Health Agency." The surveyor reviewed the missing documentation on the resident's discharge form with the SW. The SW agreed the document was not complete with information for continued care of the resident when she was discharged from the facility. The surveyor asked who was responsible for completion of the Discharge form. The DON, who was in the room talking with another surveyor, stated the UM (Unit Manager) and other nurses who have been trained. The SW stated she would look to see if the resident received Home Health when she was discharged home.</p> <p>On 8/27/14 at 11:10 AM, the surveyor asked the DON what the process was to get the information on the Discharge form that the physician and</p>	F 284	<ul style="list-style-type: none"> Then starting on 09/29/2014, the Interdisciplinary Discharge Team will review anticipated discharges during the scheduled IDT stand up meeting to address and ensure accuracy and completeness of the applicable discharge forms. <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</p> <p>Monitoring will be done through:</p> <p>The Director of Nurses or designee will review at least 3 discharges to ensure applicable discharge forms are filled out completely and accurately.</p> <p>Monitoring will start on 10/01/2014. This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3.</p> <p>The facility Director of Nursing or designee will submit to the Administrator or his/her designee and to the QA&A Committee her findings and/or corrective actions taken during the quarterly QA&A Committee Meeting.</p> <p>Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee quarterly meeting.</p>	
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135136	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/27/2014
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NAME OF PROVIDER OR SUPPLIER QUINN MEADOWS REHABILITATION & CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1033 WEST QUINN ROAD POCATELLO, ID 83202
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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 284	<p>Continued From page 7</p> <p>resident signed. The DON stated, "The UM's are generally the ones who work on the discharge paperwork. The paperwork for the Home Health referral would be given to the UM and the UM fills out the discharge form. The UM is also the one who reconciles the drugs the resident is on and puts it on the discharge paperwork for the physician to sign." The DON was asked who gave the PT referral to the UM, and she stated, "The PT would be the one to give it to them." When asked which UM filled out the discharge form, the DON stated, "There is no way to tell who filled it out. The nurse's signature at the bottom is the nurse who discharged the resident."</p> <p>On 8/27/14 at 11:25 AM, the SW provided the paperwork she had sent to the Home Health agency. The Home Health referral had a physician signature in both places where it was handwritten to "sign" but the document was not dated or timed. The SW also provided a Discharge form that documented: -Home Health: Written in was "[The name of the Home Health agency]. -3 of the 4 sections which included boxes to check for Home Health services to be provided, were marked. The physician had signed the form on 7/30/14. The resident and nurse had not signed the form.</p> <p>The surveyor reviewed the discrepancies in the forms the SW had provided from her files and the forms in the chart, and the SW stated, "Yes I do see what you are saying." She was asked who had completed the 2 sets of the forms and she stated, "I am not sure where they came from."</p> <p>On 8/27/14 at 11:55 AM, the Administrator was provided the 2 conflicting discharge forms with</p>	F 284		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 284	<p>Continued From page 8</p> <p>the physician signature and the same date, but different documentation, and was asked how that happened. He stated, "I can't tell you how that happened."</p> <p>2. Resident # 1 was admitted to the facility on 3/18/14 and discharged on 4/17/14. The residents diagnoses included care involving use of rehabilitation procedures, unspecified episodic mood disorder, and mild mental retardation.</p> <p>An Inpatient Psychiatric Evaluation from a local hospital for the resident, dated 3/14/14 and signed by a physicia, documented: -Current Medications included: Aricept 10 mg daily. -Past Psychiatric History: "...Most recent psychiatric hospitalization was January. She has had med trials of..., most recently Aricept and ..." -Plan: "Continue outpatient medications."</p> <p>The resident's facility physician medication orders included: -Donepezil (Aricept) Hydrochloride 10 mg (milligrams) tab(let) po (every) HS (hour of sleep) DX (diagnosis) Dementia. NOTE: The admission orders to the facility which included the Aricept were documented by the same physician who treated the resident in the psychiatric unit she was admitted from.</p> <p>The resident's Medication Administration Record (MAR) from 3/18/14, the day of admission, to 4/17/14, the day of discharge, documented the resident received Donepezil every HS except on the 3/18/14.</p> <p>The resident's Discharge Form signed by the physician on 4/16/14, by the nurse on 4/17/14,</p>	F 284		

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F 284	<p>Continued From page 9</p> <p>and by the resident with no documented date, documented the medications the resident had received while at the facility and which she was to continue at home. The medications listed did not include the Donepezil.</p> <p>NOTE: The physician who signed the Discharge Form was not the same from the physician who admitted the resident.</p> <p>On 8/27/14 at 12:45 PM, the surveyor, with the Administrator and the DON, compared the discharge medications with the medications the resident had received while in the facility and asked why the Aricept was not on the discharge form. The Administrator stated, "If he would have wanted her on it he would have wrote it on there." The DON stated, "That is who (resident) was brought to our attention with a problem on the discharge, the medication was not on it. We identified we had problems and then started a QA and did education with the nurses."</p> <p>On 8/27/14 at 1:00 PM, UM #3 was asked to describe the process she used to complete the Discharge Form. UM#3 stated, "I copy all the medications from the MAR which the resident took while in the facility onto the discharge form, fax it to the physician and the physician will make changes on it as needed, then sign it and send it back." The DON, who was present, was asked what they did when more than one physician was involved in the resident's care. The DON stated, "I don't know, you would have to ask the doctor." When asked if it was the facility's responsibility to make sure the discharge doctor knew all the medications the resident was on while in the facility, she gestured, yes.</p>	F 284			

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NAME OF PROVIDER OR SUPPLIER QUINN MEADOWS REHABILITATION & CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1033 WEST QUINN ROAD POCATELLO, ID 83202
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F 284	<p>Continued From page 10</p> <p>On 8/27/14 at 2:50 PM, the Administrator, DON and SW were informed of the findings. No additional information was provided.</p> <p>3. Resident #2 was admitted to the facility on 5/12/14 and discharged on 5/28/14 with multiple diagnoses to include right hip fracture, diabetes mellitus type 2, and hypertension.</p> <p>The resident's Occupational Therapy Discharge Summary dated 5/27/14 documented, "Pt made excellent prog[ress]. D/C home [with] temp[orary] support. Needs Home Health therapy for [increased] safety and [independent] funct[ional] mob[ility]."</p> <p>The resident's Face-to-Face Encounter dated 5/27/14 documented, I certify that, based on my findings, the following services are medically necessary home health services: - Physical Therapy for balance, gait training, and Therapeutic Exercises. The patient will also need the following dependent services: - Occupational Therapy was checked; however it had a line drawn through it with a hand written initial. -Further, I certify that my clinical findings support that this patient is homebound because: Leaving [home] requires a taxing effort.</p> <p>It could not be determined why the Occupational Therapy order on the Face-to-Face referral form had been lined through as the therapist had identified in the discharge summary the resident needed, Home Health therapy for increased safety and independent functional mobility.</p>	F 284		
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F 284	<p>Continued From page 11</p> <p>The resident's Discharge Form dated 5/28/14 included an order for Home Health service; however, did not include a referral to a Home Health agency.</p> <p>On 8/27/14 at 10:45 AM, when asked who was designated to set up Home Health for the resident's when they were discharged, the SW stated she was. The SW stated a Home Health referral form, with the discharge orders, history and physical and the resident's Face Sheet is sent to the Home Health Agency. When asked why the resident did not have a Home Health referral form in his/her medical record to document the services had been set up for the resident prior to discharge, the SW stated, "I am not sure," and she would look for the Home Health referral form and paperwork in her office.</p> <p>On 8/27/14 at 12:00 PM the SW was asked if she had located the Home Health referral for Resident #2. The SW stated she could not find it. No further information was provided to resolve this concern.</p> <p>4. Resident #4 was admitted to the facility on 4/29/14 and discharged on 5/19/14 with multiple diagnoses to include small bowel obstruction, hypertension, and osteoporosis.</p> <p>The resident's Admission Orders dated 5/2/14 documented, Oxygen at 2 liters per minute (LPM) continuous.</p> <p>* The resident's Discharge form dated 5/19/14 indicated the resident required the following Home Health services upon discharge: - Physical Therapy - Occupational Therapy</p>	F 284			

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F 284	<p>Continued From page 12</p> <ul style="list-style-type: none"> - Nursing Services - O2 instructions: _____ was left blank and was not included as medication to be continued upon discharge. - Equipment recommendations: Did not include order for oxygen concentrator. <p>The resident's medical record was reviewed and did not include a physician's order to discontinue the oxygen prior to or upon discharge of the resident. Additionally, the medical record did not include a Home Health referral form to request the care and services as identified above.</p> <p>During an interview on 8/27/14 at 10:45 AM, the SW said she was the person designated to set up Home Health for the residents when they discharged from the facility. When asked about the process to set up home health for residents when they were discharged, the SW stated, "This form (Home Health referral form), with the discharge orders, history and physical and the resident's face sheet is sent to the Home Health Agency." The SW was asked to provide the completed copy of the Home Health referral form for Resident #4.</p> <p>On 8/27/14 at 11:25 AM, the SW was asked if she had found the Home Health referral form for Resident #4. The SW stated she could not find the form it was not in the resident's medical record. When asked if the resident had Home Health provided to her when she was discharged the SW stated, "I am not sure."</p> <p>On 8/27/14 at 12:50 PM the DON and LN #4 was asked, if a resident is admitted with an order for oxygen and the facility does not receive a physician's order to discontinue the oxygen order</p>	F 284			

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F 284	<p>Continued From page 13</p> <p>during the resident's stay is it included on the Discharge Form. LN #4 stated, "No, when a resident discharges the nurse checks the resident's room air oxygen saturation, if the oxygen saturation is ninety percent or above the oxygen is not included in the discharge medications." LN #4 was asked if it was in a nurse's scope of practice to discontinue a medication without a physician's order. LN #4 did not provide an answer. The DON stated it is not in nurse's scope of practice to discontinue a medication without a physician's order and she could not explain why the oxygen order was not on the Discharge Form.</p> <p>On 8/27/14 at 2:50 PM, the Administrator, DON and SW were informed of the findings. No additional information was provided.</p>	F 284		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001635	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/27/2014
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NAME OF PROVIDER OR SUPPLIER
QUINN MEADOWS REHABILITATION & CARE (

STREET ADDRESS, CITY, STATE, ZIP CODE
1033 WEST QUINN ROAD
POCATELLO, ID 83202

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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 complaint investigation of your facility. The surveyors conducting the survey were: Susan Gollobit, RN, Team Coordinator Amy Barkley, RN, BSN The survey team entered the facility on 8/27/14 and exited the facility on 8/27/14.	C 000	<i>Preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the accuracy or truthfulness of any facts alleged or any conclusions set forth in this allegation of deficiencies by the State Licensing Authority. Accordingly, the facility has drafted this Plan of Correction in accordance with Federal and State Laws which mandate the submission of a Plan of Correction as a condition for participation in the Medicare and Medicaid program. This Plan of Correction shall constitute this facility's credible allegation compliance with this section.</i>	
C 882	02.203.02,a Resident Identification Requirements a. Patient's/resident's name and date of admission; previous address; home telephone; sex; date of birth; place of birth; racial group; marital status; religious preference; usual occupation; Social Security number; branch and dates of military service (if applicable); name, address and telephone number of nearest relative or responsible person or agency; place admitted from; attending physician; date and time of admission; and date and time of discharge. Final diagnosis or cause of death (when applicable), condition on discharge, and disposition, signed by the attending physician, shall be part of the medical record. This Rule is not met as evidenced by: Refer to F283 related to resident's discharge summary.	C 882	Refer to tag F- 283	10/01/14

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SEP 18 2014
FACILITY STANDARDS

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

TITLE (X6) DATE

ADMINISTRATOR 9/17/14

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001635	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/27/2014
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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

October 10, 2014

Michael E. Borup, Administrator
Quinn Meadows Rehabilitation & Care Center
1033 West Quinn Road
Pocatello, ID 83202-2425

FILE COPY

Provider #: 135136

Dear Mr. Borup:

On **August 27, 2014**, a Complaint Investigation survey was conducted at Quinn Meadows Rehabilitation & Care Center. Susan Gollobit, R.N. and Amy Barkley, R.N. conducted the complaint investigation.

During the investigation, the resident's chart and the charts of three other residents were reviewed for discharge orders. These four residents' discharge forms, recapitulation of stay forms and home health forms were reviewed.

On August 27, 2014, the Administrator, DoN, Social Worker and the Unit Manager were interviewed.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00006617

ALLEGATION:

The RP stated the resident was on Aricept before going to the facility, while in the facility and was supposed to go home with it. Aricept was not on the discharge orders, and consequently, the resident did not receive the medication after leaving the facility for a three-month period.

Michael E. Borup, Administrator
October 10, 2014
Page 2 of 2

FINDINGS:

The resident identified in the complaint had been on Aricept prior to admittance to the facility and every day while in the facility. The facility failed to carry forward the Aricept medication onto the discharge form, and the resident went home without orders for the Aricept.

The facility was cited for inaccurate discharge forms and incomplete recapitulation of stays.

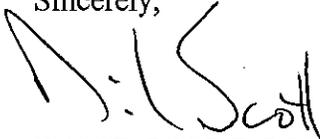
CONCLUSIONS:

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

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

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

Sincerely,

A handwritten signature in black ink, appearing to read "D. Scott". The signature is written in a cursive style with a large initial "D" and "S".

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

DS/dmj