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
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CERTIFIED MAIL: 7000 1670 0011 3315 1767

September 5, 2014

Kelly Spiers, Administrator
Teton Post Acute Care & Rehabilitation
3111 Channing Way
Idaho Falls, ID 83404-7534

Provider #: 135138

Dear Mr. Spiers:

On **July 25, 2014**, a Recertification, Complaint Investigation and State Licensure survey was conducted at Teton Post Acute Care & Rehabilitation 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. Due to additional information that was provided toward the end of that survey, but not reviewed until writing the complaint, the complaint investigation was re-opened with an exit date of **August 28, 2014**. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be an isolated deficiency that constitutes 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 17, 2014**. Failure to submit an acceptable PoC by **September 17, 2014**, may result in the imposition of civil monetary penalties by **October 7, 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 <u>documented and retained</u> for the follow-up survey. In your Plan of Correction, please be sure to include:

  a. Specify by job title <u>who</u> 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. <u>Frequency</u> 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. <u>Start date</u> of the audits;

- Include dates when corrective action will be completed <u>in column (X5)</u>.

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

- The administrator must sign and date the first page of both the federal survey report, Form CMS-2567 and the state licensure survey report, State Form.

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

As noted in the Bureau of Facility Standards' letter of **August 6, 2014**, following the **Recertification, Complaint Investigation and State Licensure** survey of **July 25, 2014**, we have already made the recommendation to the Centers for Medicare and Medicaid Services (CMS) for Denial of Payment for New Admissions and termination of the provider agreement on **January 25, 2015**, if substantial compliance is not achieved by that time.

The findings of noncompliance on **August 28, 2014**, has resulted in a continuance of the remedy(ies) previously outlined in the **August 6, 2014**, letter.

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

If you believe these deficiencies have been corrected, you may contact Lorene Kayser, L.S.W., Q.M.R.P. or David Scott, R.N., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, 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.

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 17, 2014**. If your request for informal dispute resolution is received after **September 17, 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

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

LK/pmt
Enclosures

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

PRINTED: 09/03/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	135138		C 08/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TETON POST ACUTE CARE & REHABILITATION	3111 CHANNING WAY IDAHO FALLS, ID 83404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following deficiencies were cited during the conclusion of a complaint investigation survey of your facility on 8/28/14. The investigation of the complaint was initiated during the recertification survey of 7/21-25/14. The survey team included: Linda Kelly, RN. Survey Definitions: DNS = Director Nursing Services/Director of Nursing MAR = Medication Administration Record.	F 000	RECEIVED OCT 23 2014 FACILITY STANDARDS	
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to administer medications prescribed during a resident's stay in the facility. This was true for 1 of 11 sample residents (#10). Failure to administer cardiologist prescribed Coumadin (anticoagulant) and Plavix (antiplatelet) and to decrease Lisinopril (antihypertensive) as ordered created the potential for Resident #10 to develop blood clots and/or low blood pressure both of which could lead to life threatening events. Findings included: Resident #10 was readmitted to the facility on 6/2/14 and left the facility Against Medical Advice (AMA) on 6/11/14.	F 333	*F333* • ***How corrective action accomplished for the identified residents?*** Resident#10 discharged from the facility on 6/11/14. • ***How you will identify other residents with the potential of being affected by the same practice?*** Residents in the facility are at risk for the failed practice. Physician orders have been reviewed to validate they have been processed correctly.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Administrator	10-22-14

/ deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that er safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days owing 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 's following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued gram participation.

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F 333	Continued From page 1 Review of the resident's medical record revealed Coumadin and Plavix were not included in the Nursing Facility Admission Orders, dated 5/31/14, a preprinted Physician Order Sheet form with handwritten entries, dated 6/3/14, or a June 2014 Physician Order Sheet (electronic form), with a print date of 6/6/14. Lisinopril 10 milligrams (mg) daily by mouth (PO) was included in all of the aforementioned orders. Review of the resident's medical record revealed there were 5 handwritten prescriptions all signed by a cardiologist and dated June 5, 2014 in the chart. There were no marks, notations, or initials on any of the handwritten prescriptions to indicate they had been noted by facility staff. The 5 handwritten prescriptions were: * Plavix 75 mg, 1 PO every day; * Coumadin 5 mg, 1 PO every Tuesday and Thursday; * Coumadin 2.5 mg, 1 PO every Monday, Wednesday, Friday, Saturday, and Sunday; * Stop Lisinopril 10 mg, start Lisinopril 5 mg, 1 PO every day; and, * A PT/INR (a laboratory test to monitor bleeding time) on 6/12/14 then monthly or as directed. There was also a Telephone Order, dated 6/9/14, by the resident's facility physician to decrease Lisinopril to 5 mg daily. The resident's June 2014 MARs contained documentation that Lisinopril 10 mg was initiated on 6/3 and decreased to 5 mg daily on 6/10/14. However, the MARs did not include any entries for Coumadin or Plavix.	F 333	• ***Address what measures will be put in place to ensure deficient practice will not recur.*** Nursing staff will be re-educated by the Director of Nursing and or designee on processing physician orders and communicating those orders with the pharmacy per policy. Nursing staff will be re-educated by the Director of Nursing and or designee on returning medications to the pharmacy only after the medication record and physician order are reviewed to validate the resident is no longer taking the medication.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135138		C 08/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TETON POST ACUTE CARE & REHABILITATION	3111 CHANNING WAY IDAHO FALLS, ID 83404

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F 333	Continued From page 2 On 7/25/14 at 9:15 a.m., the DNS was asked about the 5 handwritten prescriptions. The Administrator was present during the interview. The DNS stated, "I think the resident had the prescriptions and brought them in later." The DNS reviewed the prescriptions and acknowledged they were dated 6/5/14. She said the prescriptions "were not handed to the facility." When asked if the resident received Coumadin or Plavix while in the facility, the DNS stated, "No. I don't have them on the MAR." When asked for documentation regarding when the facility received the 5 handwritten prescriptions, the DNS stated, "No. No documentation they ever saw them." The DNS said the handwritten prescriptions were provided to the facility right before the resident left the facility AMA. A copy of the handwritten prescriptions was requested. On 7/25/14 at about 10:30 a.m., a copy of the handwritten prescriptions was received and reviewed. There were no marks, notations, or initials on this copy to indicate the prescriptions had been noted by facility staff. On 7/25/14 at about 12:30 p.m., a second copy of the handwritten prescriptions was included with other requested documentation. Because it was a second copy, it was not reviewed in detail at the time. However, later review of the second copy revealed there was a "FAXED" stamp and "To Pharmacy 6-5-14 1520 [3:20 p.m.]" with someone's initials in handwriting on this copy. On 8/28/14 at 9:15 a.m., the Administrator was contacted by telephone and asked to provide the telephone number for the facility's pharmacy provider. He provided the number.	F 333	• ***How will the plan be monitored to ensure the solutions are sustained?*** The Director of Nursing or designee will start audits on 9/12/14 for the identified issues that will be completed 3 days a week X4 weeks, 2 days a week X4 weeks, and 1 day a week for 1 month. To validate that physician orders are being process and communicated to the pharmacy. The Director of Nursing or designee will start audits on 9/29/14 for the identified issues that will be completed 3 days a week X4 weeks, 2 days a week X4 weeks, and 1 day a week for 1 month. To validate that medications are being reviewed before being returned to the pharmacy.	

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F 333	Continued From page 3 On 8/28/14 at 9:48 a.m., the facility's pharmacy provider supervisor was interviewed by telephone. When asked if the pharmacy received a fax of the prescriptions for Coumadin, Plavix, and Lisinopril for the resident, the supervisor said the fax was received on 6/5/14 at 3:30 p.m. When asked if the pharmacy provided the medications, the pharmacy supervisor said the medications were delivered to the facility on 6/6/14 at 3:35 a.m. and a facility staff member signed for the medications. On 8/28/14 at 10:10 a.m., in a follow-up telephone call, when asked if the pharmacy had any involvement with the MARs when medication changes were made, the pharmacy supervisor stated, "No we don't." On 8/28/14 at 10:40 a.m., the facility's Administrator and DNS were interviewed by telephone. When asked to describe how medication orders were received and processed, the DNS stated, "A nurse signs for them [medications], they are reviewed after the delivery person leaves, and items not needed are returned to the pharmacy at a later time." When asked how new medications were added to a resident's MAR, the DNS stated, "Through order processing. When a nurse sees an order, they write "noted" on it, make an entry in nursing notes, and add it to the MAR." The Administrator and DNS were informed the resident's Coumadin and Plavix were delivered to the facility on 6/6/14 at 3:35 a.m. When asked if the resident received those medications, the DNS stated, "Not that I'm aware of." When asked who signed for the medications on 6/6/14, the DNS said a Registered Nurse who was no longer with the facility. The Administrator said the resident's	F 333	All findings will be brought to CQI monthly for further review and educational opportunities. • *The ED is responsible for compliance* *Compliance date is ~~10/28/14~~* 11/3/14 Chg per facility e-mail 11/4/14 NR	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	135138		C 08/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TETON POST ACUTE CARE & REHABILITATION	3111 CHANNING WAY IDAHO FALLS, ID 83404

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F 333	Continued From page 4 Coumadin and Plavix, "Were returned in full to the pharmacy." The DNS said the nurse who saw the prescriptions and faxed them to the pharmacy, "Didn't follow through with the process." Resident #10 did not receive prescribed Coumadin or Plavix for 6 days and the dose of Lisinopril was not decreased for 2 days when the facility failed to process orders for the medications.	F 333		

PRINTED: 09/03/2014
FORM APPROVED

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	MDS001775		08/28/2014

NAME OF PROVIDER OR SUPPLIER: TETON POST ACUTE CARE & REHABILITATIO

STREET ADDRESS, CITY, STATE, ZIP CODE: 3111 CHANNING WAY, IDAHO FALLS, ID 83404

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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 conclusion of a complaint investigation survey of your facility on 8/28/14. The investigation of the complaint was initiated during the recertification survey of 7/21-25/14. The survey team included: Linda Kelly, RN.	C 000		
C 798	02.200,04,a MEDICATION ADMINISTRATION Written Orders 04. Medication Administration. Medications shall be provided to patients/residents by licensed nursing staff in accordance with established written procedures which shall include at least the following: a. Administered in accordance with physician's dentist's or nurse practitioner's written orders; This Rule is not met as evidenced by: Refer to F333 as it related to significant medication errors regarding Coumadin, Plavix, and Lisinopril.	C 798	*C798* Refer to the plan of correction for F333 on the 2567.	

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OCT 23 2014
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OCT 23 2014
FACILITY STANDARDS

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3ORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 10-22-14

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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
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P.O. Box 83720
Boise, ID 83720-0009
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CORRECTED COPY

September 5, 2014

Kelly Spiers, Administrator
Teton Post Acute Care & Rehabilitation
3111 Channing Way
Idaho Falls, ID 83404-7534

Provider #: 135138

Dear Mr. Spiers:

On **August 28, 2014**, a Complaint Iuvestigation survey was conducted at Teton Post Acute Care & Rehabilitation. Linda Kelly, Registered Nurse conducted the complaint investigation.

The complaint was investigated during the annual Federal Recertification and State Licensure survey conducted July 21 through July 25, 2014, and a follow-up complaint investigation conducted August 28, 2014.

The following documentation was reviewed:

- The identified resident's medical record including the June 2014 Medication Administration Record (MAR);
- The identified resident's History and Physical, dated May 30, 2014, and hospital Discharge Summary, dated May 31, 2014;
- The medical records of nine other residents reviewed for Quality of Life and Quality of Care concerns;
- The closed medical record of another resident who had been discharged;
- The facility's grievance files;
- The facility's accidents and injury files;
- The facility's investigations of allegations of abuse;
- Resident Council meeting minutes for May through July 2014;
- Staffing records for the days in question; and,

Call light audits for the days in question.

FILE COPY

During the survey week, staff interactions with residents, including the provision of cares for residents, and staff responses to call lights were observed.

Interviews were conducted as follows:

- Three residents in a group interview were asked about abuse, care provided by staff, and call light response times;
- Five individual residents were asked about abuse, care provided by staff, and call light response times;
- Two residents' family members were asked about abuse, care provided by staff, and call light response times;
- Five direct care staff were asked about abuse and staffing;
- Three supervisory staff were asked about abuse and staffing;
- Various staff were asked about call light response times;
- The Director of Nursing Services (DNS) was asked about abuse, staffing, and call light response times;
- The Administrator was asked about abuse, staffing, and call light response times;
- The facility's van driver was asked about transporting resident; and,
- The Ombudsman.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00006540

ALLEGATION #1:

The complainant stated:

a. Facility staff treated an identified resident "like a child" and were generally "rude."
b. An identified resident: was accused of inappropriately touching a female staff member and facility staff repeatedly "lectured" the resident and "threatened" to report the resident to law enforcement for "sexual assault" or to be "beaten" by facility staff for any sexual misdeeds.
c. Facility staff ignored requests to not allow "certain staff" to come in contact with an identified resident.
d. An identified resident: was kept in the wheelchair the entire time he was there.
e. An identified resident: was was not allowed to leave his resident's room except to attend therapy.

FINDINGS #1:

1. Per the interviews with individual residents, the group of residents, and family members, facility staff were respectful, nice, and helpful. The facility's Administrator and DNS said they were not

aware of and had not been informed of disrespectful or rude behavior by staff members.

2. The identified resident's medical record contained documentation the resident was "inappropriate" with female staff on June 6 and June 7, 2014. Facility staff responded appropriately when the resident was "asked to act and conduct self appropriately" on June 6 and a male Certified Nursing Assistant (CNA) was assigned as a one-to-one staff with the resident on June 7.

   Grievance files did not include any grievances indicating staff lectured residents, threatened to report residents to law enforcement or threatened physical aggression toward residents. In addition, there were no grievances, which indicated any resident(s) requested certain staff not be allowed contact with them.

   Review of abuse investigations revealed the facility thoroughly investigated and unsubstantiated an allegation, made twenty-six days after a resident left the facility, that staff had lectured, threatened to contact law enforcement and threatened physical aggression toward the resident.

3. The identified resident's medical record contained documentation that the resident used a wheelchair and occasionally used a walker for mobility, was "in and out" of the her/his room, was out of the facility twice with the spouse and was out of the facility two other times for medical appointments.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The complainant said facility staff went through an identified resident's personal belongings without the resident's knowledge or consent and confiscated cigarettes.

FINDINGS #2:

Review of the grievance files revealed there were no complaints that staff went through resident's personal belongings without their permission or of missing cigarettes.

The Administrator said he became aware of a complaint that staff had gone through a resident's personal belongings without their permission and confiscated cigarettes twenty-six days after a resident left the facility. The Administrator said he was not aware of any other complaints that staff had gone through any resident's personal belongings or took their belongings without the resident's permission. The Administrator said the facility was "a completely non-smoking facility" and local hospital Discharge Planners were aware of the facility's non-smoking policy. The Administrator

provided a written statement from a local hospital Case Manager which noted "patients being referred 'to the facility' are informed by Case Management staff that it is a non-smoking facility."

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The complainant said that on June 2, 2014, the facility's van driver on drove dangerously while transporting an identified resident from an area hospital.

FINDINGS #3:

Review of the grievance files revealed there were no complaints about dangerous driving by the facility's van driver. Review of accident and incident reports revealed there were none which involved dangerous driving in the facility's van.

Per the interview with the van driver, she pulled off to the side of the street briefly one day to make an adjustment. A police officer stopped shortly afterward and asked if everything was "okay." When told everything was okay, the officer left. The driver denied driving dangerously in the facility van and said she had never had any traffic citations, "Not even one."

The Administrator said the van driver did report that a police officer stopped to check on her after she had stopped on the side of the street one day. The Administrator said no citations were issued. The Administrator said he became aware of a complaint about dangerous driving by the van driver twenty-six days after a resident left the facility. The Administrator said he was not aware of any other complaints about dangerous driving by the van driver.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

The complainant said facility staff did not answer call lights for "at least" 20 minutes when an identified resident was in one room and the call light response wait time increased to 45-60 minutes after the resident was moved to a room nearer the nurse's desk.

FINDINGS #4:

Interviews with the resident group, individual residents, family members, the Ombudsman, staff, and review of residents' medical records and grievance investigations, revealed staff responses to call lights and resident needs did exceed twenty minutes, at times.

The complaint was substantiated and the facility was cited at F353 for failure to maintain sufficient staffing levels to meet residents' needs.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #5:

The complainant said an identified resident began experiencing repeated falls. Staff responded by "threatening" to send the resident to "a mental hospital" because the resident wasn't waiting for staff to respond to call light summons and kept falling down trying to self-toilet.

FINDINGS #5:

The identified resident's hospital Discharge Summary, dated May 31, 2014, documented "multiple falls" before the resident's admission to the facility.

The identified resident's medical record contained documentation that the resident was oriented to the resident's room and call light upon admission and the resident was able to make her/his needs known. The facility implemented a Fall Risk Care Plan on June 3, 2014. The resident fell six times between June 4 and June 7, 2014, while attempting to self transfer or ambulate. The resident's spouse was present each time and the call light was noted as accessible each time. However, the call light was used only once, on June 4 at eleven thirty p.m., after a fall. On June 9, 2014, the resident and spouse reported another fall while they were out of the facility. The facility revised the fall care plan to include neurological checks every fifteen minutes for an hour, then every thirty minutes for an hour after each fall. The facility increased the frequency of routine checks to every one to two hours, added non-skid socks while in bed, lowered the bed, placed a fall mat by the bed, locked the wheelchair brakes when it was at the bedside, changed the resident's room to one closer to the nurses' station, added one-to-one staffing, considered possible transfer for psychological evaluation, and repeatedly re-educated and encouraged the resident to use the call light to summon staff for assistance. On June 6, after a fall, the resident said, "I don't want to bother you guys." And, on June 9, the resident refused to allow a one-to-one-staff to accompany her/him to a doctor's appointment.

Per the interview with the DNS, a psychological evaluation was considered "because of impulsivity

and multiple falls." The DNS said she discussed the evaluation with the resident only once, on June 6, 2014, and "made it clear it was just for evaluation" and the resident "could come back to the facility."

The Social Service Designee was not available during the survey week. Social Service Progress Notes (PN), dated June 6, 2014, documented the resident "sexually grabbed" a Certified Nursing Assistant twice "in the crouch," the resident was moved to a room closer to the nurses' station, and information was faxed to a psychiatric facility "for possible admit due to negative behaviors." A PN, dated June 9, 2014, documented a one-to-one staff was added on June 7 "due to falls and negative behaviors." And, a June 11, 2014 PN documented the resident left the facility against medical advice (AMA) after the potential consequenses of leaving AMA were explained to the resident and the resident's father.

All of the residents and family members interviewed denied being threatened with mental hospital placement if they did not use the call light. In addition, the residents said they were not aware of any such threats by staff.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #6:

The complainant said cardiac medications were not provided to an identified resident until "late night" of June 3, 2014, and then didn't receive all cardiac and "blood thinning" medications prescribed. The resident had an appointment with a cardiac doctor on June 5, 2014. The cardiac doctor was upset that the resident was not given warfarin or Plavix and wrote new prescriptions to replace those discontinued by the attending physician at facility. The resident did not receive the medications prescribed on June 5, 2014, for 36 hours.

FINDINGS #6:

The identified resident's medical record contained documentation that Amiodarone (an antiarrhythmic) ordered twice a day and Lisinopril (an antihypertensive) 10 milligrams (mg) ordered daily were the only cardiac medications ordered when the resident was admitted to the

facility on June 2, 2014. However, no blood thinning medications were ordered when the resident was admitted on June 2, 2014.

The resident's medical record also contained 5 handwritten prescriptions dated June 5, 2014 and signed by a cardiologist. The prescriptions included 2 strengths of Coumadin to be administered on different days; Plavix; and to decrease the Lisinopril to 5 mg every day. There was no indication in the resident's medical record that prescriptions had been noted by facility staff and the orders processed.

A Telephone Order, dated June 9, 2014, by the resident's facility physician, did decrease the Lisinopril to 5 mg daily.

The medical record contained documentation that Amiodarone was administered at 8 p.m. on June 2 (the day of admission), then 8 a.m. and 8 p.m. daily until the resident left the facility against medical advice (AMA) on June 11, 2014. And, that Lisinopril 10 mg was administered daily from June 3 through June 5, was held on June 6 and 7, and administered June 8 and 9. Then, Lisinopril 5 mg was administered on June 9 and 10.

A pharmacy supervisor confirmed that the pharmacy received the prescriptions dated June 5, 2014, and sent Coumadin, Plavix, and Lisinopril to the facility.

The DNS said facility staff did not process the orders. The DNS confirmed that the resident did not receive Plavix or Coumadin while in the facility.

The complaint was substantiated and the facility was cited at F333, significant medication error, for failure to administer physician prescribed medications as ordered.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #7:

The complainant said Physical Therapy (PT) and Speech Therapy (ST) were not provided for an identified resident.

FINDINGS #7:

The identified resident's Physician Order Sheet, dated June 2, 2014, included orders for Physical Therapy (PT) and Speech Therapy (ST).

A PT evaluation was done June 4, 2014 and PT visits were conducted June through June 7, June 9, and June 10, 2014.

A ST evaluation was done June 10, 2014 and ST visits were conducted June 10 and 11, 2014.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #8:

The complainant said the identified resident was denied access to a physician of choice.

FINDINGS #8:

Per interviews with residents and review of the grievance files and accident and injury reports revealed no complaints that residents were denied access to a physician of their choice.

Per interview with the DNS, the resident wanted a physician who did not provide services in the facility. The DNS said the resident was informed of this and that the facility's medical director would provide care for the resident. The DNS said the resident agreed for the facility's medical director as her/his physician while the resident was in the facility.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #9:

The complainant said that an inventory of an identified resident's personal belongings was not taken until several days after the resident was admitted and the resident was missing clothing.

FINDINGS #9:

The resident's medical record included an undated one page Personal Belonging Inventory which listed a wheelchair, a Merry Walker, a CD/DVD player, eleven DVDs, a television, a cell phone with a cracked screen, a phone charger, two pairs of jeans, two shirts, one pair of socks, three underwear, one fuzzy blanket, and one throw.

Review of the grievance files revealed there were none regarding missing clothing for the identified resident.

The Administrator said he was unaware of a complaint about the resident's missing clothing until twenty-six days after the resident left the facility against medical advice.

The complaint was substantiated and the facility was cited at F514 for failure to ensure personal belongings were inventoried when they were brought to the facility.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #10:

The complainant said an identified resident was denied PRN (as needed) pain medications after 6 hours when the PRN order was every 4 hours.

FINDINGS #10:

The identified resident's Nursing Facility Admission Orders, dated May 31, 2014, included Norco (analgesic medication) every four hours by mouth as needed (PRN) for pain.

The resident's June 2014 MAR documented Norco was administered on the day of admission, June 2, then three to four times a day from June 3 through June 8, twice on June 9, four times on June 10, and twice on June 11 before the resident left the facility against medical advice (AMA). The resident was out of the facility during the evening shift on June 3, during the day shift on June 5, during the day and evening shifts on June 8, and during the day shift on June 9.

The resident's medical record contained documentation that the resident had moderately severe to severe pain which diminished to mild, or was relieved, or the resident slept after the PRN Norco was administered. There was no documented evidence the resident was refused when PRN pain medication was requested.

Interviews with residents and family members and review of the grievance files and accident and incident reports revealed there were no complaints that residents were refused when PRN pain medication was requested.

Per interview with the Administrator and DNS, they were not aware of any complaints that the resident was denied requested pain medication until twenty-six days after the resident left the facility AMA.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

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,

Lorene Kayser

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

LKK/lj