



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 2236

September 12, 2013

Richard M. Ord, Administrator
Bennett Hills Center
1220 Montana Street
Gooding, ID 83330-1856

FILE COPY

Provider #: 135134

RE: **RECERTIFICATION AND STATE LICENSURE SURVEY REPORT COVER LETTER**

Dear Mr. Ord:

On **August 30, 2013**, a Recertification and State Licensure survey was conducted at Bennett Hills Center by the Department of Health & Welfare, 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 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 25, 2013**. Failure to submit an acceptable PoC by **September 25, 2013**, may result in the imposition of civil monetary penalties by **October 15, 2013**.

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

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. This monitoring will be reviewed at the follow-up survey, as part of the process to verify that the facility has corrected the deficient practice. Monitoring must be documented and retained for the follow-up survey. In your Plan of Correction, please be sure to include:
 - a. Specify by job title who will do the monitoring. It is important that the individual doing the monitoring has the appropriate experience and qualifications for the task. The monitoring cannot be completed by the individual(s) whose work is under review.
 - b. Frequency of the monitoring; i.e., weekly x 4, then q 2 weeks x 4, then monthly x 3. A plan for 'random' audits will not be accepted. Initial audits must be more frequent than monthly to meet the requirement for the follow-up.
 - c. Start date of the audits;
- Include dates when corrective action will be completed in column 5.

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

effective date of the remedy when determining your target date for achieving compliance.

- The administrator must sign and date the first page of both the federal survey report, Form 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 4, 2013 (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 4, 2013**. A change in the seriousness of the deficiencies on **October 4, 2013**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **October 4, 2013** includes the following:

Denial of payment for new admissions effective **November 30, 2013**. [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 **March 1, 2014**, if substantial compliance is not achieved by that time.

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

If you believe these deficiencies have been corrected, you may contact Loretta Todd, R.N. or Lorene Kayser, L.S.W., Q.M.R.P., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0036; phone number: (208) 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.

Richard M. Ord, Administrator
September 12, 2013
Page 4 of 4

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 30, 2013** 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 25, 2013**. If your request for informal dispute resolution is received after **September 25, 2013**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact us at (208) 334-6626.

Sincerely,



LORETTA TODD, R.N., Supervisor
Long Term Care

LT/dmj
Enclosures

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

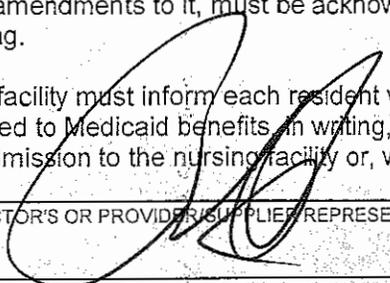
PRINTED: 09/10/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135134	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/30/2013
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NAME OF PROVIDER OR SUPPLIER BENNETT HILLS CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1220 MONTANA STREET GOODING, ID 83330
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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	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the annual federal recertification survey of your facility.</p> <p>The surveyors conducting the survey were: Brad Perry, LSW Arnold Rosling, RN, BSN, QMRP Debbie Bernamonti, RN</p> <p>Survey Definitions: MDS = Minimum Data Set assessment CAA = Care Area Assessment DON = Director of Nursing LN = Licensed Nurse CNA = Certified Nurse Aide ADL = Activities of Daily Living MAR = Medication Administration Record MASD = Moisture Associated Skin Damage</p>	F 000	<p>“This Plan of Correction is prepared and submitted as required by law. By submitting this Bennet Hills Care & Rehabilitation Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency.”</p> <p style="text-align: right;">RECEIVED SEP 25 2013</p>	
F 156 SS=C	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>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.</p> <p>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</p>	F 156	<p>F156</p> <p style="text-align: right;">FACILITY STANDARDS</p> <ol style="list-style-type: none"> 1. The admission packet was updated by the administrator on 8/30/13 to include that the medical records could be requested either verbally or in writing and “with some exceptions” was deleted. 2. Residents currently residing at the center were notified of the changes 	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 9/25/13
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A deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that 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 156	<p>Continued From page 1</p> <p>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 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</p>	F 156	<p>made to the admission packet by the Administrator on or before 10/4/13.</p> <p>3. The IDT was educated Federal requirements of the admission packet by the Administrator on or before 10/4/13.</p> <p>4. Beginning the week of 10/4/13 a review of new admissions packets by the Administrator to ensure that they include accurate instructions for request of medical records will be completed weekly X4 weeks and then monthly X2 months. The results of these audits will be reported to the Performance Improvement Committee for review monthly X3 months or until resolved. The Administrator is responsible for monitoring and follow-up.</p>	10/4/13

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F 156	<p>Continued From page 2</p> <p>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 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 admission packet and staff interview, it was determined the facility failed to ensure residents requesting copies of their medical records were able to obtain them by asking for them. This had the potential to affect all residents in the facility including 10 of 10 (#s 1-10) sampled residents. Findings include: The facility's admission packet was reviewed. Part IV - "Your Rights Regarding Your Health Information" at "c. Right to Access to Personal Health Information," page 6 documented, "You have the right to look at or get copies of your health information. You must submit your request</p>	F 156		

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F 156	Continued From page 3 in writing to the address listed in the contact information at the beginning of this Notice. We may deny your request to inspect or receive copies. " On 08/28/13 at 2:25 p.m. the Administrator was interviewed. He stated that he would honor the Federal regulations and then follow up with his corporate office. On 08/29/13 at 1:15 p.m., the new admission packet was provided to the survey team which indicated the "...request must be submitted verbally or in writing" However, the same paragraph informed the resident that "with some exceptions, you have the right to review and copy your medical information." F156 states, "The resident or his or her legal representative has the right upon an oral or written request, to access all records pertaining to him or herself including current clinical records within 24 hours..."	F 156		
F 248 SS=D	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 observation, record review and staff interview, it was determined the facility failed to provide an activities program which met the needs of 1 of 6 (#4) sampled residents reviewed for activities. This had the potential to negatively impact the resident's psychosocial status due to long periods of time spent without meaningful	F 248	F248 1. Resident #4 was assessed by the Licensed Social Worker for any adverse effects related to the alleged non-compliance on 9/26/13 with none noted. On 9/29/13 an activity assessment was completed by the Activities Director for resident #4 to identify resident's	

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F 248	<p>Continued From page 4 activity or interactions. Findings include:</p> <p>Resident #4 was admitted to the facility on 5/12/10 with multiple diagnoses including Alzheimer's disease, congestive heart failure, and hearing loss.</p> <p>The Resident's Annual MDS dated 5/20/13 coded the resident's Cognitive Skills for Daily Decision Making as Moderately impaired.</p> <p>The Resident's Annual MDS dated 5/20/13 in the Activities CAA Triggers Summary coded the resident likes:</p> <ul style="list-style-type: none"> * Doing things with groups of people, * Participating in favorite activities, * Participating in religious activities or practices. <p>The Resident's Activity/Recreation Assessment dated 2/4/13 and reviewed by the Activity Director on 5/20/13, documented past and current interest, "Wheelchair rides weather permitting." Under the additional information section the Activity Director documented, "Res[ident] enjoys looking at his clothes and other belonging [sic] will spread them over much of his room. Res. is a very private man. Only stays on edges of groups for approx[imately] 15 min[utes]. Does not always allow staff to escort him to act[ivity] groups."</p> <p>The Resident's Activities Care Plan documented the following interventions: 9/9/11-"Assist Resident with independent activities. IE folding clothes and organizing room. Visit with Resident when he has his photo album out of his family. Resident like to Reminisce about family and long past [sic]." 8/24/12-"Visit resident 1:1 prn to assure resident is satisfied with independent act[ivities] and assist</p>	F 248	<p>activity preferences. Resident #4's Activity programming and plan of care were updated by the Activity Director on or before 10/4/13 to reflect his preferences and leisure needs.</p> <p><i>See page 5A for #2 per email from admin on 10/03/2013 @ 4:03pm db</i></p> <p>3. The Activities Director was reeducated on or before 10/4/13 by the Regional Consultant on developing activities programming that meets the resident's preferences and leisure needs.</p> <p>4. Beginning the week on 10/4/13 an audit of 3 residents activity assessments, programs, and care plans will be completed by the Administrator or designee to ensure that activity programming meets the residents needs will be completed weekly X4 weeks and then monthly X2 months. The results of these audits will be reported to the Performance Improvement Committee for review monthly X3 months or until resolved. The Administrator is responsible for monitoring and follow-up.</p> <p style="text-align: right;">10/4/13</p>

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F 248	<p>Continued From page 4</p> <p>activity or interactions. Findings include:</p> <p>Resident #4 was admitted to the facility on 5/12/10 with multiple diagnoses including Alzheimer's disease, congestive heart failure, and hearing loss.</p> <p>The Resident's Annual MDS dated 5/20/13 coded the resident's Cognitive Skills for Daily Decision Making as Moderately impaired.</p> <p>The Resident's Annual MDS dated 5/20/13 in the Activities CAA Triggers Summary coded the resident likes:</p> <ul style="list-style-type: none"> * Doing things with groups of people, * Participating in favorite activities, * Participating in religious activities or practices. <p>The Resident's Activity/Recreation Assessment dated 2/4/13 and reviewed by the Activity Director on 5/20/13, documented past and current interest, "Wheelchair rides weather permitting." Under the additional information section the Activity Director documented, "Res[ident] enjoys looking at his clothes and other belonging [sic] will spread them over much of his room. Res. is a very private man. Only stays on edges of groups for approx[imately] 15 min[utes]. Does not always allow staff to escort him to act[ivity] groups."</p> <p>The Resident's Activities Care Plan documented the following interventions: 9/9/11-"Assist Resident with independent activities. IE folding clothes and organizing room. Visit with Resident when he has his photo album out of his family. Resident like to Reminisce about family and long past [sic]." 8/24/12-"Visit resident 1:1 prn to assure resident is satisfied with independent act[ivities] and assist</p>	F 248	<p>activity preferences. Resident #4's Activity programming and plan of care were updated by the Activity Director on or before 10/4/13 to reflect his preferences and leisure needs.</p> <p>2. A review of residents activity programs and plan of care was completed by the Activities Director or designee on or before 10/4/13. Changes were made to activity programs and care plans as indicated.</p> <p>3. The Activities Director was reeducated on or before 10/4/13 by the Regional Consultant on developing activities programming that meets the resident's preferences and leisure needs.</p> <p>4. Beginning the week on 10/4/13 and activity assessments, programs, and care plans will be completed by the Administrator or designee to ensure that activity programming meets the residents needs will be completed weekly X4 weeks and then monthly X2 months. The results of these audits will be reported to the Performance Improvement Committee for review monthly X3 months or until resolved. The Administrator is</p>	10/4/13	

RECEIVED

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OCT 03 2013

FACILITY STANDARDS

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F 248	<p>Continued From page 5 PRN." 2/4/13-"Resident enjoys looking at his clothes and belongings and often spreads them over much of his room. Assist prn to tidy up as he allows." 2/6/13-"Enjoys going outside weather permitting. Take Res. out on North hall outside area as he chooses." 5/31/13-"Resident enjoys sorting bolts."</p> <p>The Resident's Exit Seek Care Plan documented in part on 5/31/13 the following interventions, "Staff will offer resident an activity of interest" and "Staff will offer to take resident outside."</p> <p>The Resident's Interdisciplinary Progress Notes documented in part by nursing staff the following: 7/16/13-"Exit seeking x [times] 6." 8/14/13-"Res has been exit seeking x 2..." 8/26/13-"...attempt to elope x 1, redirected successfully..." Note: The progress notes did not indicate what interventions were tried if any on 7/16 and 8/14/13 and did not include what intervention was successful on 8/26/13.</p> <p>The Resident's Activity Program Participation Record from 6/1 to 8/26/13, documented an independent activity of, "sorting clothes/belongings" happened every day, however, the chart did not contain a section for a sorting bolts activity and did not record any walks outside had occurred. Also no refusals of walks were documented.</p> <p>The Resident's One-to-One Activity Participation Log from 6/1 to 8/26/13, documented a total of 10 visits with the resident.</p> <p>During the survey, the following observations</p>	F 248		

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F 248	<p>Continued From page 6</p> <p>were made:</p> <p>8/26/13 1:05 PM-The Resident was in his room sitting in his wheelchair with his pants unzipped. 1:10 PM-An aide stopped by his room to assist the resident with his pants and she closed the door, washed her hands, and then left the room without offering an activity to the resident.</p> <p>8/27/13 9:20 AM-The Resident was in his room in his wheelchair with a pile of clothes near the doorway and a pile against the wall near the window. [Note: The Resident had a separate set of clothes which he did not wear and sorted them into piles on his bedroom floor.] 11:02 AM-The Resident was laying on his bed and the piles of clothes were on the floor. 11:56 AM-An aide set up the Resident's lunch tray on the table in his room and asked if he needed assistance with eating and he declined. 2:00 PM-The Resident was sitting in his wheelchair looking out the window and a housekeeper was in the room cleaning the room. The piles of clothes were not found on the floor. 3:40 PM-The Resident was in his room actively making piles of clothes on his floor. 6:03 PM-The Resident was in his room with piles of clothes on the floor.</p> <p>8/28/13 10:53 AM-The Resident was in his room in his wheelchair while looking at the wall and the floor. [Note: A Newspaper reading activity was happening at the same time of this observation in the dining room.] 2:00 PM-The Resident was in his room in his wheelchair staring at nothing in particular. The floor was clear of clothes. 3:05 PM-Similar to the previous observation. 3:35 PM-In the facility TV/Lobby area a Karaoke</p>	F 248		

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F 248	<p>Continued From page 7</p> <p>activity was taking place and the Activity Director, Social Worker, Dietary Manager, and one other staff member were assisting three residents participate in the activity. Note: Resident #4 was not one of the residents at the activity.</p> <p>On 8/28/13 at 10:45 AM LN #2 was interviewed about Resident #4's activities. When asked if she or other staff take him to activities or outside, she said they try to but sometimes he does not like to go and becomes combative.</p> <p>On 8/28/13 at 10:55 AM CNA #3 was interviewed about Resident #4's participation of activities. When asked if the resident ever played with bolts as outlined in his care plan, she said they will bring in a basin of bolts to the resident, "when he asks."</p> <p>On 8/29/13 at 11:25 AM the Activity Director was interviewed regarding the Resident's Activity Care Plan and Participation Record. When asked about why the Participation Record not have a place to document the resident working with bolts, she said there probably should be. When asked why the resident was not offered to go outside as his care plan directs, she stated, "I encourage him to go outside, but he turns me down." When asked where those refusals are documented, she stated, "My charting could be better." Note: The last Activity Progress note in the residents chart was made on 5/20/13.</p> <p>On 8/29/13 at 11:50 AM the DON was interviewed and asked if his exit seeking behavior was related to his lack of activity, she stated, "I don't think it's because he is bored." She also added, "We take him outside." When the surveyor informed her the resident was observed on several occasions and</p>	F 248		

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F 248	Continued From page 8 was never offered to go outside nor was there documentation in the Participation Record or the Progress Notes regarding taking him outside, she said they would work on documenting it better. On 8/29/13 at 2:25 PM the Administrator, the DON, and the Regional Nurse were informed of the issue. No further information was provided by the facility.	F 248		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined that the facility failed to ensure social services were provided for 1 of 10 sampled residents (#8) to attain or maintain the highest practicable physical, mental and psychosocial well-being. This had the potential to cause harm if residents were not identified for medical-related social services and had avoidable declines in physical, mental or psychosocial well-being. Findings include: Resident #8 was admitted 08/30/10 with a diagnosis of Multiple Sclerosis. The resident also has a history of poor appetite and spitting out medications. The Resident was reviewed in the PDR (Psychopharmacological Drug Reduction) committee in 5/9/13. A Consultation Report from	F 250	F250 1. Resident #8 was reassessed for depression by the Licensed Social Worker on 9/4/13. Resident #8 was seen by her physician on 9/5/13 and new orders for changes in her antidepressant medications were received and implemented. 2. A review of residents receiving antidepressants was completed by the Licensed Social Worker on or before 10/4/13 to ensure that current medications are effective. Follow up was completed as needed. 3. The IDT was reeducated on assessing residents for depression and treatment for depression by the Regional Consultant on or before 10/4/13.	

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F 250	<p>Continued From page 9</p> <p>the Pharmacist documented, "Lamictal 25 mg twice a day [for Multiple Sclerosis] was discontinued and Baclofen [for Multiple Sclerosis] was reduced to 20 mg twice daily (from four times daily) in an effort to improve appetite and hopefully reduce spitting episodes." The Lamictal which the resident had been on for years was discontinued abruptly.</p> <p>An Interdisciplinary Team (IDT) note, dated 07/11/13 documented that Mirtazapine (Remeron), an antidepressant prescribed for adjustment disorder with depressed mood, was decreased from 30 mg by mouth at bedtime every day to 15 mg by mouth every day at bedtime.</p> <p>A Physician's Progress note dated 07/11/13, addressed the issue of poor appetite for rationale of decrease dose and, "discussion with nursing staff to follow closely."</p> <p>The PHQ-9 (Personal Health Questionnaire-9) completed as part of the the 5/14/13 Quarterly MDS scored the resident as a 5 (5-9 is mild depression).</p> <p>The PHQ-9 from the 8/21/13 Quarterly MDS scored the resident as a 21 (20-30 severe depression).</p> <p>IDT documentation on 07/12/13, 07/13, 07/24, 07/31, 08/10/13 showed, "no adverse side effects (ASE) from reduction of Mirtazapine, continues to spit out foods and medications."</p> <p>There was no Social Service documentation from 05/2013 to 08/29/13 to show the resident was monitored for symptoms of depression. In addition, the Social Service (LSW) chairs the PDR committee. The resident's record did not include documentation of discussions conducted within the meetings.</p> <p>These findings were discussed with LSW and Nurse Consultant on 08/29/13 at 1:45 p.m. The</p>	F 250	<p>4. Beginning the week of 10/4/13 an audit of 3 residents on antidepressant therapy by the Director of Nursing to ensure that treatment for depression was effective will be completed weekly X4 weeks and then monthly X2 months. The results of these audits will be reported to the Performance Improvement Committee for review monthly X3 months or until resolved. The Director of Nursing is responsible for monitoring and follow-up.</p>	10/4/13

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F 250	Continued From page 10 LSW indicated that Resident #8 did not have an increase in her depression and stated she (LSW) sees her all the time. No additional information was provided. The reduction changes were done without adequate monitoring to ensure the resident didn't have increased depression.	F 250		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined that facility did not revise care plans for 2 of 10 (#s 5 and 6) sampled residents. The care plans did not reflect revisions for call	F 280	F280 1. Resident #6's care plan was updated by the Director of Nursing or designee on 09/03/13 to reflect current physician order for catheter. Resident #6 was assessed for potential adverse effects related to alleged non-compliance by the Director of Nursing on or before 9/26/13 with no concerns noted. Resident #5's care plan was updated by the Director of Nursing or designee on 09/23/13 to include one intervention for call light placement. 2. Residents with care planned interventions for catheters were reviewed by the Director of Nursing or designee on or before 09/23/13 to ensure that care and services provided per MD order and that care plan reflects current MD order.	

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F 280	<p>Continued From page 11</p> <p>light placement or specific indwelling catheter order. This had the potential to result in harm if residents did not receive appropriate care due to lack of direction in the care plan. Findings include:</p> <p>1. Resident #6 was admitted 09/24/12 with a diagnosis of paralysis agitans, urinary obstruction, atrial fibrillation, depressive disorder and congestive heart failure. The Comprehensive Care Plan initiated 07/14/12 included an intervention for, "catheter size 18 French 10cc balloon." The 09/24/12 recapitulated Physician's Orders documented a "Coude 18 FR (French) with 5 cc balloon to bedside drainage at bedtime every 30 days." NOTE: A Coude catheter is usually recommended for males with prostate problems who have difficulty urinating. The male urethra has curves as it travels to the bladder so a Coude tip can be easier to insert and more comfortable than a straight one. The correct information was documented on the Treatment Administration Record. On 08/29/13 at 9:30 a.m. LN # 1 was interviewed. She stated she did not know why there was a discrepancy in plan of care.</p> <p>2. Resident #5 was admitted to the facility on 7/22/11 with diagnoses of unspecified debilitation, diabetes type II without complications, paralytic syndrome affecting nondominant side and cerebrovascular disease.</p> <p>The most recent Quarterly MDS, dated 7/23/13, documented the resident:</p> <ul style="list-style-type: none"> * Was cognitively intact with a BIMS of 15, * Required extensive assistance for bed mobility, transfers, dressing and personal hygiene, * Was frequently incontinent of urine. 	F 280	<p>A review of call light placement was completed by the Director of Nursing or Designee on or before 09/23/13 to ensure that call lights are within reach of residents and that call light needs are reflected in the plan of care</p> <p>3. Licensed Nurses were reeducated on completing a plan of care that accurately reflects care and services provided and physician orders by the Staff Development Coordinator on or before 10/4/13.</p> <p>4. Beginning the week of 10/4/13 an audit of 3 care plans will be completed by the Director of Nursing or designee to ensure that Care Plans reflect current physician orders and care and services provided will be completed weekly X4 weeks and then monthly X2 months. The results of these audits will be reported to the Performance Improvement Committee for review monthly X3 months or until resolved. The Director of Nursing is responsible for monitoring and follow-up.</p> <p style="text-align: right;">10/4/13</p>

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F 280	Continued From page 12 The resident's care plan, dated 7/20/13, documented three interventions for call lights at the problem of "risk for falls." These interventions were: **Call light to be placed in resident hand at all time while in her room. * Place call light within easy reach of resident. * Resident has a history of non-compliance with call light use. Check with resident r/t [related to] care needs, when toilet[sic], medication [sic] pass etc." The DON was interviewed, on 8/28/13 at 10:15 a.m., about the call light and where it was to be placed. The call light had been observed during the survey located on the over bed table. The DON indicated that the call light was to be within reach of the resident and the care plan would be fixed. On 8/28/13 at 10:45 a.m. the clinical nurse consultant said the care plan was "fixed."	F 280			
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by:	F 315	F315 1. Resident #5 bowel and bladder was assessed by the Director of Nursing or Designee on 10/25/13 and an individualized toileting plan was implemented. Resident #5 was assessed by the Director of Nursing on 9/26/13 with skin intact and no other adverse effects related to alleged non-compliance.		

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F 315	<p>Continued From page 13</p> <p>Based on staff interview and record review, the facility had failed to develop and implement a toileting program for 1 of 5 (# 5) sampled residents with incontinence. This had the potential to harm the resident because incontinence can cause MASD. Findings include:</p> <p>Resident #5 was admitted to the facility on 7/22/11 with diagnoses of unspecified debilitation, diabetes type II without complications, paralytic syndrome affecting nondominant side and cerebrovascular disease.</p> <p>The most recent quarterly MDS, dated 7/23/13, documented the resident: *Was cognitively intact with a BIMS of 15, *Required extensive assistance for bed mobility, transfers, dressing and personal hygiene, *Was frequently incontinent of urine.</p> <p>The resident's care plan dated 7/20/13, documented a problem of: "Incontinence of bladder r/t overflow." The two approaches were: ** Frequently offer to assist resident to the toilet. * 7/31 - Resident prefers to ask for help she notifies [sic] staff when she needs to be changed."</p> <p>On 5/29/13 the resident had a Bowel and Bladder Continence Evaluation completed. The conclusion was the resident had overflow incontinence, and based on the evaluation the resident would benefit with a "scheduled voiding" program.</p> <p>The form defined "Scheduled Voiding Program" as: "Appropriate for a resident who has extensive to severe cognitive impairment and requires extensive assistance or is dependent on staff for physical functioning. The behavior technique</p>	F 315	<p>2. Incontinent residents were reviewed to ensure that toileting needs are being met as indicated by their bowel and bladder assessment on or before 10/4/13 by the Director of Nursing or Designee.</p> <p>3. Licensed Staff were reeducated by the Staff Development Coordinator on or before 10/4/13 on completing bowel and bladder assessments and implementing a toileting plan that reflects resident's needs.</p> <p>4. Beginning the week on 10/4/13 an audit of 3 incontinent residents will be completed by the Director of Nursing or Designee to ensure that toileting plans are implemented based of the assessment that indicates residents toileting needs will be completed weekly X4 weeks and then monthly X2 months. The results of these audits will be reported to the Performance Improvement Committee for review monthly X3 months or until resolved. The Director of Nursing is responsible for monitoring and follow-up.</p>	10/4/13

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F 315	<p>Continued From page 14</p> <p>matches the voiding patterns established on the 72 hour voiding diary. There is no systematic effort to encourage the resident to delay voiding and resist urges. Scheduled voiding is usually toileting every three to four hours as established by the voiding diary. An interdisciplinary care plan will be developed to reflect the current residents incontinence needs along with the CNA care cards...."</p> <p>The DON was interviewed on 8/28/13 at 10:15 a.m. about the lack of a scheduled voiding care plan. She stated, the voiding "should have been care planned." The corporate nurse consultant was interviewed 8/28/13 at 10:45 a.m.; however, no further information was provided.</p> <p>468 483.70(h)(3) CORRIDORS HAVE FIRMLY SS=E SECURED HANDRAILS</p> <p>The facility must equip corridors with firmly secured handrails on each side.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure all corridors were equipped with handrails. This affected 8 of 10 (#s 1-6 & 8-9) sampled residents and had the potential to affect other residents who frequented the corridors without handrails. This practice created the potential for residents to not have a handrail for stability when and if needed. Findings included:</p> <p>On 8/26/13 at 2:48 PM, on 8/27/13 from 5:40-6:00 PM, and on 8/28/13 from 11:00-11:30 AM during the environmental tour, the following</p>	F 315	<p>F468</p> <p>1. Rails were added to the areas identified to be missing rails outside of room #12, #1, #25, by the crash cart and CAN office, outside of the Director of Nursing office, and outside of room #43 by the Director of Maintenance on 9/23/13.</p> <p>2. A round of the facility was completed by the Director of Maintenance and the Administrator on or before 10/4/13 to identify any other areas of missing rails with none noted.</p> <p>3. The Director of Maintenance was educated on the requirements for handrails in corridors by the Administrator on or before 10/4/13.</p>

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F 468	<p>Continued From page 15</p> <p>handrails were observed to be missing:</p> <ul style="list-style-type: none"> * Approximately 10 inches outside of Resident Room #12, * Approximately 6 inches outside of Resident Room #1, * Approximately 1 1/2 feet outside of Resident Room #25's alcove, * Approximately 3 feet outside of Resident Room #25, * Approximately 2 1/2 feet between the Crash Cart and C.N.A. Offices, * Approximately 4 1/2 feet outside of the DON's Office, * Approximately 2 feet outside of Resident Room #43. <p>On 8/28/13 during the environmental tour from 11:00-11:30 AM with the Maintenance Supervisor and the Administrator, the missing handrails were brought to their attention. While outside of the Crash Cart room the Maintenance Supervisor stated there was, "Never a handrail there." While observing the missing handrails outside of Resident Room #25 he stated, "I've never noticed it before." He said he will work on adding handrails to all the areas above and look for any other places which may need them.</p>	F 468	<p>4. Beginning the week on 10/4/13 a round of the center will be completed by the Administrator to ensure that rails in the corridors are in place. This audit will be completed weekly X4 weeks and then monthly X2 months. The results of these audits will be reported to the Performance Improvement Committee for review monthly X3 months or until resolved. The Administrator is responsible for monitoring and follow-up.</p>	10/4/13	

Bureau of Facility Standards

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NAME OF PROVIDER OR SUPPLIER
BENNETT HILLS CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
1220 MONTANA STREET
GOODING, ID 83330

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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 annual licensure survey of your facility.

The surveyors conducting the survey were:
Brad Perry, LSW
Arnold Rosling, RN, BSN, QMRP
Debbie Bernamonti, RN

C 000

RECEIVED
OCT 02 2013
FACILITY STANDARDS

C 159 02.100.09 RECORD OF PTNT/RSDNT PERSONAL VALUABLES

09. Record of Patient's/Resident's Personal Valuables. An inventory and proper accounting shall be kept for all valuables entrusted to the facility for safekeeping. The status of the inventory shall be available to the patient/resident, his conservator, guardian, or representative for review upon request.

This Rule is not met as evidenced by: Based on record review and staff interview it was determined the facility failed to ensure an accounting of personal possessions was completed upon discharge for 1 of 10 sample residents, (#10). Findings include:

Resident #10 was admitted to the facility on 3/3/09 with diagnoses of cerebrovascular disease, dementia, and congestive heart failure and was discharged on 6/11/13.

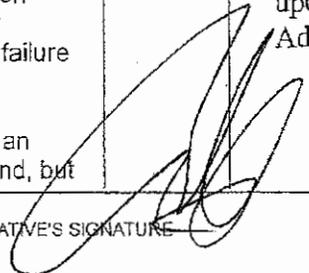
During review of Resident #10's records, an inventory of personal belongings was found, but

C 159

C159

1. Resident number 10 was discharged from the center on 6/11/13.
2. A review of residents who have discharged from the center in the last 30 days was completed by Health Information Manager on or before 10/4/13 to ensure that personal belongings are accounted for.
3. The Social Worker and Licensed Nurses were educated on the requirements for documenting disposition of personal belongings upon resident discharge by the Administrator on or before 10/4/13.

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



TITLE Administrator (X6) DATE 10/2/13

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001235	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/30/2013	
NAME OF PROVIDER OR SUPPLIER BENNETT HILLS CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1220 MONTANA STREET GOODING, ID 83330		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 159	<p>Continued From page 1</p> <p>was not signed by the responsible party or by a facility staff member upon discharge. No progress notes were found which documented the resident's personal effects were ever returned.</p> <p>On 8/28/13 at 1:00 PM the Regional Nurse was interviewed about the belongings form. When asked if she could find where it was signed or where a progress note was made, she stated, "I don't see it." At 1:30 PM, the Regional Nurse came back to the surveyor to report she had checked with staff about the personal items and was told the resident's spouse had been taking belongings home prior to the resident's death, but it was never documented in the chart.</p> <p>On 8/29/13 at 2:25 PM the Administrator and DON were informed of the issue. No other information was provided.</p>	C 159	<p>4. Beginning the week on 10/4/13 1 discharged resident will be reviewed to ensure that personal belongings are accounted for upon discharge. These audits will be completed weekly X4 weeks and then monthly X2 months. The results of these audits will be reported to the Performance Improvement Committee for review</p> <p>monthly X3 months or until resolved. The Administrator is responsible for monitoring and follow-up.</p>	10/4/13
C 389	<p>02.120,03,d Sturdy Handrails on Both Sides of Halls</p> <p>d. Handrails of sturdy construction shall be provided on both sides of all corridors used by patients/residents.</p> <p>This Rule is not met as evidenced by: Refer to F468 regarding lack of handrails.</p>	C 389	See Federal Tag (F 468 – E) for the plan of correction.	
C 411	<p>02.120,05,k All Resident Rooms Numbered</p> <p>k. All patient/resident rooms shall be numbered. All other rooms shall be numbered or identified as to purpose. This Rule is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure 17 rooms in the facility were labeled. This had the potential to effect the</p>	C411	<p>1) The signage was addressed and corrected immediately upon notification by the surveyors by the placement of temporary signage on each door. Temporary signs are still currently in place. Permanent signage was ordered on 9/9/13 from a local vendor in Twin Falls, ID; Galaxy Award and Engraving. Jennifer at Galaxy stated to the administrator that; "We should have the signage ready to be picked up within 2 weeks."</p>	10/4/13

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001235	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/30/2013
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NAME OF PROVIDER OR SUPPLIER BENNETT HILLS CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1220 MONTANA STREET GOODING, ID 83330
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C 411 Continued From page 2
residents or visitors who resided or came to the facility. Findings include:

On 8/26/13 from 10:05 AM to 10:22 AM a tour of the facility was completed. The following rooms did not have any identification on them:
* The Therapy Office,
* An Activities room,
* A Staff bathroom,
* Nine storage rooms,
* Two shower rooms,
* A Scale room,
* The MDS office,
* And a Maintenance office.

The Administrator was shown these rooms at 10:15 AM and he stated, "We will make signs for all the doors."

- C 411
- 2) All residents had the potential to be affected by the missing signage.
 - 3) The permanent signage will be installed and in place by 9/30/13. The administrator will review all signage on 10/09/13 to verify that all signs were properly placed.
 - 4) The progress of the signage will be discussed in the Quality Assurance meeting on 10/10/13.
 - 5) Corrective action will be completed by 10/10/13 the date of a Quality Assurance meeting.

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:

C 674
See Federal Tag (F 248 - D) for the plan of correction.

10/4/13

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001235	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/30/2013
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C 674	Continued From page 3 Refer to F248 regarding an activity program not met.	C 674		
C 696	02.152 SOCIAL SERVICES 152. SOCIAL SERVICES. The facility shall provide for the identification of the social and emotional needs of the patients/residents either directly or through arrangements with an outside resource and shall provide means to meet the needs identified. The program shall be accomplished by: This Rule is not met as evidenced by: Please refer to F Tag 250 as it relates to Social Services record keeping.	C 696	C 696 See Federal Tag (F 250 – D) for the plan of correction.	10/4/13
C 782	02.200,03,a,iv Reviewed and Revised iv. Reviewed and revised as needed to reflect the current needs of patients/residents and current goals to be accomplished; This Rule is not met as evidenced by: Refer to F 280 as it relates to revising the care plan.	C 782	C 782 See Federal Tag (F 280 – D) for the plan of correction.	10/4/13
C 795	02.200,03,b,xi Bowel/Bladder Evacuation/Retraining xi. Bowel and bladder evacuation and bowel and bladder retraining programs as indicated; This Rule is not met as evidenced by: Refer to F 315 for bowel and bladder retraining.	C 795	C 795 See Federal Tag (F 315 – D) for the plan of correction.	10/4/13