



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

FILE COPY

CERTIFIED MAIL: 7012 3050 0001 2125 6041

October 10, 2014

Lori A. Bentzler, Administrator
Twin Falls Center
674 Eastland Drive
Twin Falls, ID 83301-6846

Provider #: 135104

Dear Ms. Bentzler:

On **September 26, 2014**, a Recertification, Complaint Investigation and State Licensure survey was conducted at Twin Falls Center by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be an isolated deficiency that constitutes actual harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies and a similar State Form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) 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

Lori A. Bentzler, Administrator
October 10, 2014
Page 2 of 4

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 **October 23, 2014**. Failure to submit an acceptable PoC by **October 23, 2014**, may result in the imposition of civil monetary penalties by **November 12, 2014**.

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

- Address what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- Address how you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- Address what measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;
- Indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained.
- Include dates when corrective action will be completed in column (X5).

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

- 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 31, 2014 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **October 31, 2014**. A change in the seriousness of the deficiencies on **October 31, 2014**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **October**

Lori A. Bentzler, Administrator
October 10, 2014
Page 3 of 4

31, 2014 includes the following:

Denial of payment for new admissions effective **December 26, 2014**. [42 CFR §488.417(a)]

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

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **March 26, 2015**, if substantial compliance is not achieved by that time.

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

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

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **September 26, 2014** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the noncompliance at the time of the revisit, if appropriate.

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

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

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

Lori A. Bentzler, Administrator
October 10, 2014
Page 4 of 4

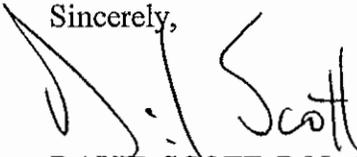
- BFS Letters (06/30/11)

2001-10 Long Term Care Informal Dispute Resolution Process
2001-10 IDR Request Form

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

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

Sincerely,

A handwritten signature in black ink that reads "D. Scott". The signature is written in a cursive style with a large, sweeping initial "D" and a clear "Scott" following.

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

DS/dmj
Enclosures

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135104	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/26/2014
NAME OF PROVIDER OR SUPPLIER TWIN FALLS CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 674 EASTLAND DRIVE TWIN FALLS, ID 83301	
(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	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the annual federal recertification and complaint survey of your facility.</p> <p>The surveyors conducting the survey were: Brad Perry, BSW, LSW, Team Coordinator Nina Sanderson, BSW, LSW Judy Atkinson, RN Rebecca Thomas, RN Susan Gollobit, RN</p> <p>The survey team entered the facility on September 22, 2014 and exited on September 26, 2014.</p> <p>Survey Definitions: ADL = Activities of Daily Living BIMS = Brief Interview for Mental Status BKA = Below the Knee Amputation BNP = Brain Natriuretic Peptide cm = Centimeters CAA = Care Area Assessment CAD = Coronary Artery Disease CHF = Congestive Heart Failure CNA = Certified Nurse Aide COPD = Chronic Obstructive Pulmonary Disease CPAP = Continuous Positive Airway Pressure DM = Diabetes Mellitus DON = Director of Nursing ESRD = End Stage Renal Disease LN = Licensed Nurse MAR = Medication Administration Record MCO = Manager of Clinical Operations MDS = Minimum Data Set assessment mg = milligrams pg/ml = picograms per milliliter PRN = As Needed</p>	F 000	<p>“This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Twin Falls 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>RECEIVED OCT 23 2014 FACILITY STANDARDS</p>	

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

Joni Beutler

TITLE

Administrator

(X6) DATE

10/21/14

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

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F 000 F 154 SS=D	Continued From page 1 RD = Registered Dietician 483.10(b)(3), 483.10(d)(2) INFORMED OF HEALTH STATUS, CARE, & TREATMENTS The resident has the right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. The resident has the right to be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure that residents or their representatives were informed of the FDA (Federal Drug Administration) black box warning for antipsychotic medications. This was true for 1 of 15 sampled residents (#8). The deficient practice had a potential to cause harm when the resident or resident's representative did not have the opportunity to make an informed decision regarding the potential risks and benefits when this type of medication was ordered for the resident's use. Findings include: Resident #8 was admitted to the facility on 11/23/11 with a primary diagnosis of unspecified intellectual disabilities and manic disorder with psychotic behavior. Resident #8's recapitulated Physician's Orders for August 2014 documented an order for "Geodon	F 000 F 154	<u>F154</u> <u>Specific Residents Identified</u> Resident #8 and her responsible party have been notified on or before 11/7/14 by the Director of Nursing or designee of the Black Box warning including the risks and benefits of the medication that was ordered. Documentation of this notification has been placed in the resident's medical record by the Director of Nursing or designee on or before 11/7/14 . There were no adverse effects to the resident. Her medication was continued as ordered. <u>Identification of Other Residents</u> Physician's orders sheets of current residents were reviewed for medications that require a black box warning. The medical record of other residents who receive medications with black box warnings have been reviewed on or before 11/7/14 by the Director of Nursing or designee to ensure that the resident or their representative have been notified of the risks and benefits of the medication that was ordered. Required notifications will	

11/13/14 per Administrator on 11/12/14 - David Scott for all ci-fations.

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F 154	Continued From page 2 [Ziprasidone HCl] 40 MG capsule by mouth [Oral]- Twice a day every day [for] Acute Psychosis." On 9/23/14 at 4:30 PM, the DON was asked whether the resident or the resident's representative had been informed of the Black Box Warning for Geodon. The DON stated there may have been a handwritten documentation of the the risk and benefits in the resident's chart but, "it will not state there is a risk of death." NOTE: Federal guidance at F154 documented, "'Informed in advance' means that the resident [or resident representative] receives information necessary to make a health care decision, including information about his/her medical condition and changes in medical condition, about the benefits and reasonable risks of the treatment, and about reasonable available alternatives." On 9/23/14 at 4:35 PM, the Administrator and DON were informed of the findings. The facility offered no further information.	F 154	be made by the Director of Nursing or designee on or before 11/7/14 on applicable findings and documented in the medical record. <u>Systemic Changes</u> Licensed nursing staff have been educated on or before 11/7/14 by the Director of Nursing or designee regarding notifications to include the need to document communication and consent to residents and resident representatives of the risks and benefits of medications with Black Box warnings. <u>Monitoring</u> Starting the week of 11/10/14, audits of 5 residents will be completed by the Director of Nursing or designee weekly for 4 weeks and then monthly x 2 months to ensure that residents receiving medications with Black Box warnings and their representatives have been notified of the risks and benefits of the medication. Results of the audits will be reported to the Performance Improvement Committee monthly for 3 months	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial	F 157		

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F 157	<p>Continued From page 3</p> <p>status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview, and record review it was determined the facility did not ensure residents' physicians and family members were consistently informed of significant changes in resident conditions. This was true for 2 of 13 (#s 5 and 6) sampled residents. The deficient practice had the potential for harm if physicians did not receive timely information to treat acute illnesses, and family members were not able to make informed decisions regarding treatment options. Findings included:</p> <p>1. Resident #6 was admitted to the facility on</p>	F 157	<p>for review and remedial interventions. The Director of Nursing is responsible for monitoring and compliance. The Performance Improvement Committee will re-evaluate the need for further monitoring after 3 months.</p> <p><u>Date of Compliance</u></p> <p>11/7/14</p> <p><u>F157</u></p> <p><u>Specific Residents Identified</u></p> <p>Residents # 5 and # 6 have been discharged from the facility. RN #3 was re-educated on the importance of updating the medical record with the resident family contact information by the Administrator on or before 11/7/14.</p>	

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F 157	<p>Continued From page 4</p> <p>7/16/14 with multiple diagnoses which included acute encephalopathy, mental status changes, and a history of COPD and CAD.</p> <p>Resident #6's Admission MDS assessment dated 7/23/14 documented the resident was cognitively intact, and it was very important for the resident to have family involved in discussions about her care.</p> <p>Resident #6's Admission Record documented her sister and her niece as emergency contact persons.</p> <p>On 7/23/14, a facility SBAR form [Situation, Background, Assessment, and Request] documented the resident was experiencing increased edema and weight, and puffiness in her face.</p> <p>The area of the form to document which family member had been notified, and the date and time of the notification, was blank.</p> <p>The form documented the resident's physician was notified at 7:40 AM on 7/23/14. However, there was no acknowledgement or response documented from the physician in the resident's record.</p> <p>On 7/29/14 the resident was admitted to the acute care hospital for a diagnosis of COPD exacerbation with fluid overload. Please see F 309 for details.</p> <p>On 9/25/14 at 10:05 AM, the DNS and MCO were asked to provide documentation that the resident's family and physician were notified of the change in the resident's condition on 7/23/14.</p>	F 157	<p><u>Identification of Other Residents</u></p> <p>The medical records of other residents in the facility have been reviewed by the Director of Nursing or designee on or before 11/7/14 to ensure that their representatives and physicians have been notified of significant changes in condition. Any required notifications have been made by the Director of Nursing or designee on or before 11/7/14.</p> <p>A review of current residents responsible party/family contact information will be completed by the Administrator or designee on or before 11/7/14 to ensure that contact information is current. Clarifications will be made by the Administrator or designee on or before 11/7/14.</p>		

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F 157	<p>Continued From page 5</p> <p>The DNS and MCO stated they could not find any additional documentation.</p> <p>On 9/26/14 at 10:00 AM the Administrator, DNS, and MCO were informed of these findings. The facility offered no further information.</p> <p>2. Resident #5 was admitted to the facility on 7/26/14 with multiple diagnoses including muscular wasting and disuse atrophy, dysphagia, and aphasia due to cerebrovascular disease.</p> <p>The resident's admission MDS Assessment dated 8/1/14, documented the resident was severely cognitively impaired.</p> <p>a. The resident's SBAR Communication Form and Progress Note on 8/26/14, documented: Under the Situation section of the form, "C/O [complaint of] painful urination, [increased] confusion." Under the Request section of the form, "Resident was refusing to work [with] therapy stating she is having burning while urinating and frequency...There also seems to be an [increased] confusion and agitation..." The form documented the physician was notified on 8/26/14 at 2:00 PM, however, the form was blank were the family notification was to be noted.</p> <p>b. The resident's SBAR Communication Form and Progress Note on 9/18/14, documented: Under the Request section of the form, "Resident noted to have cough, productive for clear-white-yellowish phlegm. Lungs [with] faint rhonchi R[ight] lower filled...Resident c/o cough but does not c/o feeling ill."</p>	F 157	<p><u>Systemic Changes</u></p> <p>Licensed nursing staff have been educated by the Director of Nursing or designee on or before 11/7/14 regarding timely notification of resident representatives and physicians of significant changes in condition and ensuring that resident family /responsible party contact information is up to date.</p> <p><u>Monitoring</u></p> <p>Starting the week of 11/10/14, audits of 5 residents will be completed by the Director of Nursing or designee weekly x 4 weeks and then monthly x 2 months to ensure that resident representatives and physicians have been notified in a timely manner of significant changes in condition and that contact information is up to date. Results of the audits will be reported to the Performance Improvement Committee monthly for 3 months for review and remedial intervention. The Director</p>	

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F 157	Continued From page 6 The form documented the physician was notified on 9/18/14 at 6:55 AM, however, the form was blank were the family notification was to be noted. On 9/25/14 at 10:25 AM, the DON said he could not find where the resident's family was notified of the change of condition. c. On 9/23/14 at 6:20 PM, Resident #5's emergency contact listed in the resident's record was called by telephone by the surveyor, however, a recording stated, "You have reached a non-working number." On 9/25/14 at 9:00 AM, the DON was informed of the attempted phone call and he stated the emergency contact was just in the facility the week before. On 9/25/14 at 9:25 AM, RN #3 informed the surveyor she had been given a new number for the resident's contact a week ago. When asked if she updated the medical record, she stated, "I didn't think about it." On 9/25/14 at 3:45 PM, the Administrator, DON, and MCO were informed of the notification and phone number issues. No further information was provided.	F 157	of Nursing is responsible for monitoring and compliance. The Performance Improvement Committee will re-evaluate the need for further monitoring after 3 months. <u>Date of Compliance</u> 11/7/14		
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone	F 164	<u>F-164</u> <u>Specific Residents Identified</u> Resident #25 has been discharged from the facility. LN #1 was re-educated by the Director of Nursing or designee on or before 11/7/14 related to maintaining confidentiality of resident medical records.		

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F 164	<p>Continued From page 7</p> <p>communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, it was determined the facility failed to maintain resident privacy and confidentiality of their personal information for 1 random resident (#25). This failure created the potential for a negative effect on the resident's psychosocial well-being related to the need for privacy and confidentiality. Findings included:</p> <p>On 9/25/14 at 9:32 AM, LN #1 was observed to leave Random Resident #25's MAR on top of the medication cart in the 100 Hall in full view when she walked away and into a resident's room. When LN #1 was asked about leaving the MAR</p>	F 164	<p><u>Identification of Other Residents</u></p> <p>A facility round was completed on or before 11/7/14 by the Director of Nursing or designee of the medication carts in the facility to ensure that the Medication Administration Record was not left open on the carts for private health information to be seen. No issues were found.</p> <p><u>Systemic Changes</u></p> <p>Facility staff were educated by the Director of Nursing or designee on or before 11/7/14 regarding maintaining resident privacy and confidentiality of personal information including keeping the MARs on the medication carts closed.</p> <p><u>Monitoring</u></p> <p>Starting the week of 11/10/14, audits of 3 medication passes will be completed weekly x 4 weeks and then monthly x 2 months by the Director of Nursing or designee to ensure that resident privacy and</p>	

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

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

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F 246	Continued From page 9 2. On 9/22/14 at 11:17 AM, Random Resident #22 was observed sitting in her wheelchair. The call light was observed to be behind the resident and on the bed approximately 4 feet from the residents reach. 3. On 9/22/14 at 11:19 AM, Random Resident #23 was observed lying in bed. The bed was in the lowest position. The call light was observed to be wrapped around the trapeze above the resident. The Surveyor asked Random Resident #23 if he could reach the call light, which he tired without success. On 9/22/14 at 11:25 AM, LN #2 was interviewed and shown the call light placement. She stated, "I don't think that is a good idea, it is way up there. When the bed is higher it's ok. [!] better put it down with you." On 9/25/14 at 3:45 PM, the Administrator and DON were informed of the findings The facility did not provide any additional information.	F 246	<u>Identification of Other Residents</u> Resident rooms have been checked by the Administrator or designee on or before 11/7/14 to ensure that call lights were placed within reach of the residents when they are in their rooms. Any findings were corrected by the Administrator or designee on or before 11/7/14. <u>Systemic Changes</u> Facility staff re-educated on or before 11/7/14 by the administrator or designee that call lights must be kept within reach of each resident. <u>Monitoring</u>		
F 252 SS=E	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, it was determined the facility failed to ensure a comfortable environment was provided for	F 252	Starting the week of 11/10/14, facility rounds will be completed by the IDT, as assigned by the administrator, weekly x 4 weeks and then monthly x 2 months to ensure that call lights are within reach of the residents. Results of the audits will be submitted to the Performance Improvement Committee monthly for 3 months for review and remedial intervention. The Performance Improvement Committee will re-		

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F 252	<p>Continued From page 10</p> <p>residents. This was true for 1 of 9 shower rooms examined (300 hallway). The deficient practice had the potential for psychosocial harm if residents became embarrassed or depressed from showering in an unappealing environment. Findings included:</p> <p>On 9/23/14 at 12:35 PM, the following in the 300 hallway shower room was observed:</p> <ul style="list-style-type: none"> *The shower area contained 3 different colors of tile (tan, white, and gray) and 3 different colors of grout on the 4 walls with one of those walls containing 75 percent tan and 25 percent white tiles, which appeared to be patched in; *One wall had a 2 by 3 foot section of tile with what appeared to be a gray colored grout applied between the tiles; *Two 4 foot sections of border material between the tile and a painted blue wall were two different colors (tan & white), and one had a foot long blue paint streak on it; *The silver colored grab bars in the shower room had tan caulking around it, which was sloppily applied and was not smooth; *The tan caulking between the tiled floor and walls was sloppily applied with a 2 inch area that had been missed near the entrance of the shower; *There was a 1 1/2 foot section of white caulking which extended between two walls and the floor, which was sloppily applied and was not smooth; and, *There was a 4 ounce unlabeled plastic cup containing a pink putrid gelatin-like substance sitting on the tiled shower ledge. <p>On 9/25/14 during the environmental tour from 10:00 to 10:20 AM, the Maintenance Supervisor was interviewed. When asked about the shower</p>	F 252	<p>evaluate the need to further monitoring after 3 months. The administrator is responsible for monitoring and compliance.</p> <p><u>Date of Compliance</u></p> <p>11/7/14</p> <p><u>F252</u></p> <p><u>Specific Residents Identified</u></p> <p>Work including repainting and installation of new tiles and new grab bars in the 300 hall shower room will be started by the Maintenance Director on or before 11/7/14. The plastic cup was discarded on or before 11/7/14 by the administrator.</p> <p><u>Identification of Other Residents</u></p> <p>Shower/bathing rooms in the facility were reviewed to ensure that they provide a homelike environment on or before 11/7/14 by the administrator. Any findings were corrected by the Maintenance Director on or before 11/7/14.</p>	

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F 252	Continued From page 11 room, he said the different tiles were put on because the facility needed to patch a few areas but could not find tile to match the original. When asked about the 2 by 3 foot section of tile with what appeared to be gray grout, he said it was not grout at all, but was the adhesive material which goes on the back side of the tiles which adheres it to the wall and he said, it was not supposed to be there. The pink gelatin-like substance was located in a wall storage unit and was still in the 4 ounce cup at the time of the interview with the Maintenance Supervisor. When asked what the substance was, he stated, "I don't know." On 9/25/14 at 3:45 PM, the Administrator, DON, and MCO were informed of the shower room issues. No further information was provided.	F 252	<u>Systemic Changes</u> Facility staff were educated by the administrator or designee on or before 11/7/14 regarding providing a comfortable, homelike environment for residents. Any issues found with the bathing/shower rooms by staff are to be reported to the Administrator for follow up and correction.		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being;	F 272	<u>Monitoring</u> Starting the week of 11/10/14, facility rounds will be completed weekly x 4 weeks and then monthly x 2 months by the Administrator or designee to ensure that the shower/bathing rooms provide a homelike environment for the residents. Results of the audits will be reported to the Performance Improvement Committee monthly for 3 months for review and remedial intervention. The Performance Improvement Committee will re-evaluate the need for further monitoring after 3		

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F 272	<p>Continued From page 13</p> <p>The resident's 8/1/14 admission MDS assessment documented the resident was severely cognitively impaired, with a BIMs of 5.</p> <p>Section V CAA Summary of the admission MDS assessment, dated 8/1/14, documented Cognitive Loss/Dementia would be care planned. The CAA Worksheet documented: "According to the resident's daughter, her mother did have some times of confusion prior to her recent hospitalization for a CVA [cerebrovascular accident], but now the confusion has increased significantly. Will proceed to care plan for cognitive loss and dementia to ensure her needs are being met [sic] and she remains safe..."</p> <p>Note: The resident's care plan was reviewed and cognitive loss was not addressed.</p> <p>On 9/24/14 at 4:55 PM, the Social Worker was interviewed and asked if a care plan was developed for cognitive loss and she stated, "It slipped through the cracks."</p> <p>On 9/24/14 at 6:30 PM, the Administrator, DON, and MCO were informed of the issue. No further information was provided by the facility.</p>	F 272	<p><u>Systemic Changes</u></p> <p>The Interdisciplinary team including the licensed social worker was educated on or before 11/7/14 by the Director of Nursing or designee regarding the requirement for care plan development when a CAA is triggered for cognitive loss/dementia.</p> <p><u>Monitoring</u></p> <p>Beginning the week of 11/10/14, audits of 5 residents will be completed weekly x 4 weeks and then monthly for 2 months by the Director of Nursing or designee of the MDS's completed to ensure that when a CAA is triggered for cognitive loss/dementia, a care plan is developed. Results of the audits will be reported to the Performance Improvement Committee monthly for three months for review and remedial interventions. The Director of Nursing is responsible for monitoring and compliance. The Performance Improvement Committee will re-evaluate the need for further monitoring after 3 months.</p>	
F 279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial</p>	F 279		

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

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F 279	<p>Continued From page 14</p> <p>needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and record review it was determined the facility failed to develop a care plan to address all pertinent items in a resident's medical history. This was true for 2 of 6 (#s 6 and 16) sampled residents. The deficient practice had the potential for harm when staff did not have guidance for monitoring a resident after she had consumed alcohol, or a plan in place for a resident's CPAP machine. Findings included:</p> <p>1. Resident #6 was admitted to the facility from an acute care hospital on 7/7/14, following a fall at home with rib fractures, alcohol abuse, CAD and CHF.</p> <p>The resident was discharged from the facility to the acute care hospital and re-admitted to the facility on 3 occasions between 7/13/14 and 8/7/14, but had consistently been in the facility since 8/7/14. With each admission, her physician's orders documented the resident could have 2 five ounce glasses of wine in the evening.</p>	F 279	<p><u>Date of Compliance</u></p> <p>11/7/14</p> <p><u>F279</u></p> <p><u>Specific Residents Identified</u></p> <p>Residents #6 and #16 have been discharged from the facility.</p> <p><u>Identification of Other Residents</u></p> <p>Resident care plans were reviewed by the Interdisciplinary Team on or before 11/7/14 to ensure that care plans accurately reflect the current resident's conditions and interventions including interventions for CPAP, supervision, toileting and interventions for prescribed alcohol use.</p>	

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F 279	<p>Continued From page 15</p> <p>On 7/13/14, her discharge from the facility was prompted by the resident obtaining extra wine from a community visitor, which required medical detoxification. With each re-admission her H&P documented the resident's history of alcohol abuse.</p> <p>Resident #6's 7/25/14 care plan documented, "Feelings of sadness, emptiness, anxiety, uneasiness, depression characterized by: ineffective coping, low self-esteem, tearfulness, motor agitation, withdrawal from care/activities, loss of independence, non-compliance related to: Loss of Independence, Family issues." The resident's history of alcohol abuse, continued use of alcohol, or history of obtaining additional alcohol were not addressed in the focus area, goals, or interventions.</p> <p>On 9/25/14 at 10:20 AM, the DNS stated the facility would not necessarily develop a care plan for alcohol abuse. The DNS stated, "We don't want to treat her differently than any other resident here. And if we did anything special regarding her alcohol use, that's what we would be doing."</p> <p>On 9/26/14 at 10:00 AM, the Administrator, DNS, and MCO were informed of these findings. The facility offered no further information.</p> <p>2. Resident #18 was admitted to the facility on 8/21/14 with multiple diagnoses which included chronic respiratory failure, obstructive sleep apnea, and dependence on machine for supplemental oxygen.</p> <p>An 8/20/14 Progress Note documented, "Accept as Admitting H & P... Obstructive Sleep Apnea...continue with his CPAP device at the</p>	F 279	<p><u>Systemic Changes</u></p> <p>The Licensed Nurses and the Interdisciplinary Team were educated by the Director of Nursing or designee on or before 11/7/14 regarding accuracy of care plans that need to reflect the current condition and interventions used for each resident and that the care plan is updated and revised as needed including updating the plan of care to reflect interventions for CPAP, supervision, toileting and interventions for prescribed alcohol use.</p> <p><u>Monitoring</u></p> <p>Starting the week of 11/10/14, 5 care plans will be audited by the Director of Nursing or designee weekly x 4 weeks and monthly x 2 months to ensure that the resident care plans reflect current resident needs. Results of the audits will be reported to the Performance Improvement Committee monthly for 3 months for review and remedial intervention. The Director of Nursing is responsible for monitoring and compliance. The</p>	

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F 279	<p>Continued From page 16 skilled nursing facility."</p> <p>An Inventory of Personal Effects on admission documented the resident was admitted to the facility with his CPAP machine.</p> <p>The resident's All Active & Discontinued Orders for August 2014 did not include an order for CPAP. However, a 9/4/14 All Active Order documented the following: *CPAP mask: Wash the mask by hand daily in warm soapy water (liquid soap). Rinse well and let dry. Day Shift Everyday; *CPAP TUBING: Washing 6 ft CPAP tubing by hand once per week in warm soapy water (liquid soap). Rinse well and air dry. Day Shift Specific days of week: Sun; *CPAP: Wash the headgear by hand as needed for soiling. Rinse well and let air-dry. PRN; and, *Wear CPAP at night. May use personal CPAP from home. Night Shift, Evening Shift Everyday."</p> <p>The 8/22/14 Care Plan for Altered Respiratory Status did not contain interventions for the use of CPAP or indicate the resident had Obstructive Sleep Apnea.</p> <p>On 9/24/14 at 10:15 AM, the DON was interviewed and stated, "The CPAP came with the patient on admission, it was in use but we did not get an order in the computer until 9/4 and it was not care planned."</p> <p>On 9/24/14 at 12:30 PM, the Administrator, MCO and DON were made aware of the CPAP concerns. No further information was provided by the facility which resolved the concerns.</p> <p>** Resident #16 was admitted to the facility on</p>	F 279	<p>Performance Improvement Committee will re-evaluate the need for further monitoring after 3 months.</p> <p><u>Date of Compliance</u></p> <p>11/7/14</p>	

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F 279	<p>Continued From page 17</p> <p>5/6/14 with diagnoses that included adult failure to thrive, muscular wasting and disuse atrophy, dysphagia oral phase and other specified rehabilitation.</p> <p>The resident's care plan for Risk of Falls dated, 5/7/14 documented interventions that included low bed, resident to wear nonslip footwear, reinforce the need to call for assistance.</p> <p>The resident's I & A (Incident and Accident) form dated 5/8/14 documented the resident had a fall while the therapist assisted the resident back to bed. The therapist had turned away from the resident and she slid from her w/c (wheel chair). The probable root cause was the resident had poor safety awareness and a recent decline in her condition. New interventions to be put in place were strict observation when up in the w/c and for the resident to remain in the line of sight of the staff.</p> <p>NOTE: The resident's I & A documented the root cause of the resident's fall was poor safety awareness, with new interventions for safety. The care plan was not updated with new interventions to prevent further falls.</p> <p>The resident's Therapy Communication to Nursing dated 5/9/14 documented, "Patient found in room attempting to self (transfer) to get to the bathroom this AM & was discovered 1/2 on bed 1/2 off bed by CNA." The problem identified was, "Patient at risk for falls (secondary) to self-(transferring) to get into the bathroom." The recommendations were, "Alarm on bed," and precautions were, "urination urgency."</p> <p>NOTE: The Communication form identified the resident was trying to self transfer to get to the bathroom. The care plan was not updated to</p>	F 279		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 279	Continued From page 18 reflect new interventions to address assistance to the bathroom. On 5/9/14, every half hour checks were implemented on the resident, by nurse staff, and continued on 5/10/14. On 5/11/14 from 6:00 AM until 10:00 PM, the resident was checked every hour and from 10:00 PM until 5:00 AM, the resident was checked every half hour. The fourth check sheet provided, did not document a date, and did not document the resident was checked from 6:00 AM until 2:00 PM. From 2:00 PM until 3:00 AM, the resident was checked hourly. No additional checks were performed. NOTE: The checks were not documented on the resident's care plan for falls. The resident's Care plan for Risk for falls was updated on 5/15/14 to include, nursing to ensure that the resident is not to be left alone when assisting with toileting needs, related to history of self transfers, decreased safety awareness. NOTE: The new intervention was not documented on the care plan til 6 days after the the resident was found 1/2 out of bed due to the need to urinate. On 9/24/14 at 11:05 AM the DON was asked why the resident only had increased supervision for 4 days, and he stated it was started on 5/9 and when she was doing "ok" on 5/12 it was increased to hourly checks and stopped. The DON verified on 5/12/14 the checks were not completed every hour and the last form he had provided did not have a date. He agreed there was blanks and the undated form was for 5/12/14.	F 279			
F 280	483.20(d)(3), 483.10(k)(2) RIGHT TO	F 280			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 280 SS=D	<p>Continued From page 19</p> <p>PARTICIPATE PLANNING CARE-REVISE CP</p> <p>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.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to revise care plans for 2 of 13 sampled residents (#s 2 and 5) and 1 random resident (#16). The care plans were not revised regarding a resident's code status and fall interventions. 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 included:</p> <p>1. Resident #5 was admitted to the facility on 7/26/14 with multiple diagnoses including hemiplegia affecting unspecified side due to</p>	F 280	<p><u>F-280</u></p> <p><u>Specific Residents</u></p> <p>Resident # 2's care plans have been reviewed and updated on or before 11/7/14 by the Interdisciplinary Team to insure that current conditions are reflected and interventions are implemented including placement of one safety mat on each side of the bed. Residents #5 and #16 have been discharged from the facility.</p> <p><u>Identification of Other Residents</u></p> <p>Current residents' care plans were reviewed by the Interdisciplinary Team by 11/7/14 to ensure that care plans accurately reflect the current resident conditions and interventions including interventions to prevent falls, and resident code status. Findings were corrected by the Interdisciplinary team on or before 11/7/14.</p>	

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

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F 280	<p>Continued From page 20</p> <p>cerebrovascular disease and aphasia due to cerebrovascular disease.</p> <p>The resident's 7/28/14 care plan documented: *Focus-"Resident desires CPR [Cardiopulmonary Resuscitation]." *Goals-"Will have CPR initiated with the absence of no pulse, no B/P [Blood Pressure], and/or no respiration." *Intervention-"Initiate CPR."</p> <p>The resident's Idaho Physician Orders For Scope of Treatment (POST) signed and dated on 7/29/14 by the resident's representative and signed and dated by the resident's physician on 7/30/14, documented the resident's code status as "DO NOT Resuscitate [No Code]; Allow Natural Death; Patient does not want any heroic or life-saving measures."</p> <p>On 9/25/14 at 9:00 AM, the DON was interviewed with the MCO present. When shown the conflicting information contained on care plan and the POST form, the DON stated, "No, they are not the same." He said the care plan had not been updated to reflect the POST information.</p> <p>2. Resident #2 was readmitted to the facility on 9/12/14 with multiple diagnoses including abnormality of gait, muscular wasting and disuse atrophy, and paralysis agitans.</p> <p>The resident's 9/19/14 fall care plan did not include fall mats as an intervention.</p> <p>The following observations were conducted: -9/23/14 at 3:15 PM, the resident was observed in bed with a fall mat to the left side of the bed; -9/24/14 at 10:30 AM, the resident was observed</p>	F 280	<p><u>Systemic Changes</u></p> <p>The Licensed Nurses and the Interdisciplinary Team were educated by the Director of Nursing or designee on or before 11/7/14 regarding accuracy of care plans including need to reflect the current condition and interventions used for each resident including interventions to prevent falls and resident code status.</p> <p><u>Monitoring</u></p> <p>Starting the week of 11/10/14, 5 care plans will be audited by the Director of Nursing or designee weekly x 4 weeks and monthly x 2 months to ensure resident care plans reflect current resident needs including interventions to prevent falls and resident code status. A report will be submitted to the Performance Improvement Committee monthly for 3 months for review and remedial intervention. The Director of Nursing is responsible for monitoring and compliance. The</p>		

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F 280	Continued From page 21 in bed with fall mats to both sides of the bed; and, -9/24/14 at 2:15 PM, the resident was observed in bed with a fall mat to the left side of the bed; On 9/24/14 at 5:40 PM, the DON was interviewed with the MCO present and was informed of the observations. When asked if fall mats were an intervention, he stated, "No, I do not see it on the care plan."	F 280	Performance Improvement Committee will re-evaluate the need for further monitoring after 3 months. <u>Date of Compliance</u> 11/7/14		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure licensed nurses (LNs) did not sign medications as administered before the medications were actually given. This was true for one Random Resident (#20) during medication pass observation. This failure created the potential for more than minimal harm should the resident not receive her medication. Findings included: Note: Informational Letter #97-3, dated April 16, 1997: The Medication Distribution Technique Clarification To Informational Letter, 96-14, from the Bureau of Facility Standards, stated, "The issue arose when the Board of Nursing received information that long term care facility staff were signing medications as given at the time of the medication preparation, not after the resident actually received the medication....the Board's expectation, and the accepted standard of	F 281	<u>F-281</u> <u>Specific Residents Identified</u> Resident # 20 has been discharged from the facility. LN #2 was re-educated by the Director of Nursing on or before 11/7/14 related to documenting medication after administration using the dot system. A medication pass competency for LN#2 was completed by the Director of Nursing or designee on or before 11/7/14 to ensure that the appropriate medication pass standards of practice are met.		

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F 281	Continued From page 22 practice, is that licensed nurses document those things they have done, not what they intend to do." On 6/25/14 at 10:56 AM, LN #2 was observed dispensing medication on the 400 Hall prior to administering, Brimonidine Tartrate Ophthalmic eye drops to Random Resident #20 when she stated, "Shucks, I signed it [the MAR] already." The LN's initials were on the MAR indicating the medication had been administered prior to the actual administration. On 6/25/14 at 3:45 PM, the Administrator and DON were informed of the findings. The facility did not provide additional information.	F 281	<u>Identification of Other Residents</u> A medication pass audit has been completed of Licensed Nurses by the Director of Nursing or designee on or before 11/7/14 to ensure licensed nurses are following accepted standards of practice. Any findings were corrected and additional education provided as needed.	
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview, and record review it was determined the facility failed to ensure a resident's physician was notified of a resident's changing medical condition, and failed to monitor pain levels as prescribed by the physician. This was true for 2 of 13 (#s 6 and 7) sampled residents. Resident #6 was harmed when her physician was not notified	F 309	<u>Systemic Changes</u> Licensed nurses were educated by the Director of Nursing or designee on or before 11/7/14 on the accepted standards of practice when administering medications to residents to ensure that nurses are not signing out medications in the Medication Administration Record prior to administration.	

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F 309	<p>Continued From page 23</p> <p>of a change in her health status for 6 days after symptoms began, and she had to be admitted to the hospital for stabilization. Resident #7 had the potential for harm when pain levels were not monitored as the physician had prescribed. Findings included:</p> <p>1. Resident #6 was admitted to the facility on 7/7/14 with multiple diagnoses which included hypoxemia, CHF and CAD.</p> <p>Resident #6's MAR documented the resident received Lasix 40 mg at 6:00 AM daily, between 7/7/14 and 7/12/14. The medication was documented as refused on 7/13/14.</p> <p>On 7/13/16, Resident #6 was discharged to the acute care hospital. Her H&P from that date documented new diagnoses of acute encephalopathy, altered mental status, and acute kidney injury. The resident remained in the acute care hospital until 7/16/14, when she was re-admitted to the facility.</p> <p>Resident #6's Physician's orders for her re-admission to the facility on 7/16/14 did not include Lasix, or other diuretic medications. The resident's MAR documented she could have 2 liters of oxygen per minute as needed to keep her oxygen saturations above 90 percent.</p> <p>On 7/16/14 Resident #6's MAR documented the resident's intake and output was to be measured each shift, to the closest cc/ml [cubic centimeter or milliliter] as possible. Of the 35 opportunities to document this value, only 4 measurement opportunities were documented. Thirty of the remaining spaces documented either "X 1," "X 2," or, "X 3", indicating the resident had voided an</p>	F 309	<p><u>Monitoring</u></p> <p>Starting the week of 11/10/14, the Director of Nursing or designee will complete 3 med pass audits per week for 4 weeks and then 1 audit weekly for 2 months. Results of audits will be reviewed by the Performance Improvement Committee for 3 months for review and remedial intervention. The Director of Nursing is responsible for monitoring and compliance. The Performance Improvement Committee will re-evaluate the need for further monitoring after 3 months.</p> <p><u>Date of Compliance</u></p> <p>11/7/14</p>		

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F 309	<p>Continued From page 24</p> <p>unmeasured amount either once, twice, or three times for that shift.</p> <p>On 7/17/14, Resident #6's care plan documented: **"Altered Respiratory Status: shortness of breath/difficulty breathing related to: COPD." Interventions included, "Monitor labs as orders [sic] and notify MD of changes as needed," and, "Observe for alterations in respiratory status including shortness of breath, pain/discomfort with breathing, abnormal lung sounds and report abnormalities to MD;" and **"Risk for fluid output exceeding intake characterized by fluid volume deficit..." Interventions included, "Observe intake and output [every] shift."</p> <p>Resident #6's 7/23/14 Admission MDS documented the resident had not experienced shortness of breath, but did require oxygen therapy.</p> <p>On 7/23/14 at 8:20 AM, a SBAR (Situation, Background, Assessment, and Request) form in Resident #6's record documented, "Situation...2 [plus] pitting edema [bilateral] legs [and] puffiness under eyes. This started on 7/22/14...stayed the same...Treatment for the last episode...Diuretics - Lasix 40 mg daily...no longer on diuretics...last weight...7/16/14 - 124 [pounds]. 7/21/14 - 127.5 [pounds] oximetry % [percent] 96 on O2 [oxygen] 2 Lpm [liters per minute]...lung CTA [clear to auscultation]...Recent Lab Results none...full code...the resident appears to have more edema...Request Diuretic orders. Reported to this nurse during shift change that the resident is having 2 [plus] pitting edema to [bilateral lower extremities] even with TED hose on. Resident [complains of] puffiness under eyes as well..."</p>	F 309	<p><u>F-309</u></p> <p><u>Specific Residents</u></p> <p>Resident #6 has been discharged from the facility. Resident #7 has had a new pain assessment completed on or before 11/7/14 by the Director of Nursing or designee. The physician for Resident #7 was contacted on or before 11/7/14 by the Director of Nursing or designee and new orders for pain monitoring were received and implemented. Resident #7's MAR was updated by the Director of Nursing or designee on or before 11/7/14 to include pre and post monitoring for pain medication.</p>	

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F 309	<p>Continued From page 25</p> <p>The form documented the above information was reported to the resident's physician at 7:40 AM on 7/23/14. However, there was no documentation of the physician's response to the information, and no new medication or treatment orders were noted.</p> <p>Resident #6's Nurse's Progress Notes (PNs) documented the facility continued to monitor edema to her lower extremities on 7/23/14 and 7/24/14. Between 7/24/14 and 7/27/14, there was only one entry in the resident's PNs, on 7/25/14 at 8:00 AM. The entry documented, "[Speech Therapy] clarification received for 7/18 and 7/22." There was no further documentation the facility had attempted to follow up with the physician regarding the concern with the resident's edema, or of any of the other concerns documented in the 7/23/14 SBAR. There was no documentation of the status of the resident's edema or breathing on 7/25/14 or 7/26/14.</p> <p>On 7/27/14 at 6:00 PM, a PN for Resident #6 documented, "90 % at 2 [liters per nasal cannula]...lungs diminished in bases..." There was still no documentation of physician awareness or follow-up from the 7/23/14 SBAR.</p> <p>On 7/28/14 at 6:45 PM, a PN documented the resident continued to use oxygen at 2 liters per minute, with a saturation of 90%.</p> <p>On 7/28/14 at 10:15 PM, an SBAR in the resident's record documented, "Situation...SOB [shortness of breath] severe...severe anxiety [due to] SOB...wheezing throughout lungs [with] severe SOB...[Physician] notified of SOB unrelieved...transfer to ER..."</p>	F 309	<p><u>Identification of Other Residents</u></p> <p>The last 30 days of progress notes of residents in the facility have been reviewed by the Director of Nursing or designee on or before 11/7/14 to ensure that their physicians and responsible party have been notified of significant changes in condition. Required notifications will be made on or before 11/7/14 by the Director of Nursing or designee and documented. Residents receiving pain medications have been reviewed by the Director of Nursing or designee on or before 11/7/14 to ensure that physician orders are being followed for pain control and monitoring and documentation in place. Findings will be corrected by the Director of Nursing or designee on or before 11/7/14.</p>		

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F 309	<p>Continued From page 26</p> <p>On 7/29/14 at 3:30 AM, Resident # 6's PNs documented, "...she is being admitted for COPD exacerbation..."</p> <p>On 7/29/14 at 1:00 AM, a laboratory report obtained at the acute care hospital documented several abnormal values. Of note, the resident's BNP value was 2097 pg/ml, with a normal range of 0-100 pg/ml.</p> <p>On 7/29/14, chest x-ray results from the acute care hospital documented, "Congestive Heart Failure or fluid overload," and, "Bilateral pleural effusions."</p> <p>On 7/30/14 an acute care hospital Inpatient Progress Note documented, "...Note that we had 3 liters [of fluid] out yesterday...she is continuing to get IV Lasix and we will maintain that at this time..."</p> <p>The resident returned to the facility on 8/2/14. Her H&P for that date documented new diagnoses of acute heart failure with fluid overload, COPD exacerbation, and macrocytic anemia.</p> <p>On 9/23/14 at 9:30 AM, during a Resident Interview, the resident described the event as a "setback" and stated, "I had edema real bad and they couldn't get the Lasix the doctor ordered for about a week. It got so bad. My legs were all swollen, and it got into my lungs. I was so scared. [The LN] had to call emergency services and the ambulance took me to the hospital. They gave me Lasix by IV there and I filled five bedpans almost immediately. It was embarrassing, but at that point I didn't care."</p> <p>On 9/24/14 at 10:05 AM, the DNS and MCO were</p>	F 309	<p><u>Systemic Changes</u></p> <p>Licensed Nurses were educated by the Director of Nursing or designee on or before 11/7/14 regarding identification of change of condition, timely notification of physicians and documentation of response, orders if applicable, and follow up to include resident responsible party notification of resident change in condition and monitoring and documentation of reported of pain levels pre and post medication as prescribed by physicians.</p>		

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F 309	<p>Continued From page 27</p> <p>asked about the events leading up to Resident #6's hospitalization. The MCO identified the SBAR form as a communication tool used for a facility nurse to formulate their thoughts on a resident's condition before calling the physician. The facility's expectation was the form should be used for nurse-to-physician communication, and a physician's response should be documented in the resident's record, either on the form, in a PN, or in terms of a new Physician's order. The DNS and MCO could not tell, from reviewing the SBAR forms, physician's orders, and PNs, whether or not the physician was actually notified of the changes in the resident's status first noted on 7/23/14, until the order was received to send her to the emergency room 5 days later. The DNS was unable to explain how the resident's urinary output could be determined from the documentation on the resident's TAR. When asked to review the labs drawn when the resident arrived at the hospital the DNS stated, "Her BNP was elevated. She was in CHF." The DNS stated he would look for additional documentation to show the physician was notified when the resident's symptoms first appeared.</p> <p>On 9/25/14 at 10:20 AM, the DNS and MCO stated they had found no further documentation.</p> <p>Resident #6 was harmed when she began to experience signs and symptoms indicating fluid overload, but the facility did not provide documentation that the physician was actually notified until 5 days later. By that time, the resident had become so ill she was frightened, required emergent transport to the hospital, had to receive IV medications, was personally embarrassed, and was admitted to the hospital for stabilization.</p>	F 309	<p><u>Monitoring</u></p> <p>Starting the week of 11/10/14, audits of 5 resident records to include medication administration records will be completed by the Director of Nursing or designee 2 x a week x 4 weeks and then monthly x 2 months to ensure that identification of change of condition occurred, physicians and responsible parties have been notified in a timely manner of significant changes in resident condition and documentation of response, orders if applicable and follow up per policy and standard of practice, and that monitoring of pain levels is being completed as prescribed by the physician and per policy. Results of the audits will be reported to the Performance Improvement Committee monthly for 3 months for review and remedial intervention. The Director of Nursing is responsible for monitoring and compliance. The Performance Improvement Committee will re-evaluate the need for further monitoring after 3 months.</p> <p><u>Date of Compliance</u></p> <p>11/7/14</p>		

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F 309	Continued From page 28 On 9/25/14 at 10:00 AM, the Administrator, DNS, and MCO were notified of these findings. The facility offered no further information. 2. Resident #7 was admitted to the facility on 9/8/12 with multiple diagnoses including Osteoporosis, Arthritis and Degenerative joint disease. The resident's Care Plan dated 7/3/14 documented an intervention, "Administer pain medication as per MD orders and note effectiveness..." The resident's September 2014 MAR documented, "Assess resident [pain] pre-medication and post-medication. 0-10 scale. Start date 9/8/14." The MAR documented Resident #7's pain was monitored per shift, not as per the MD order. On 9/23/14 at 4:30 PM, the DON was interviewed about pain monitors. When asked why the pain wasn't monitored as ordered, he stated, "The pain documentation [we use] is generic, every shift, not the best." On 9/25/14 at 3:45 PM, the Administrator and DON were informed of the issue. No further information was provided.	F 309	<u>F-310</u> <u>Specific Residents Identified</u> Resident #8 was reassessed for oral care needs by the Director of Nursing or designee on or before 11/7/14. The care plan for Resident #8 has been reviewed and revised by the Director of Nursing or designee on or before 11/7/14 to accurately reflect her interventions for oral care. <u>Identification of Other Residents</u> Residents in the facility with needs for oral care have been assessed by the Director of Nursing or designee on or before 11/7/14 to ensure that oral care interventions are in place including dental appointments if indicated. Their care plans were reviewed and updated by the Director of Nursing or designee on or before 11/7/14 to reflect current interventions for oral care and dental appointments if indicated.	
F 310 SS=D	483.25(a)(1) ADLS DO NOT DECLINE UNLESS UNAVOIDABLE Based on the comprehensive assessment of a resident, the facility must ensure that a resident's	F 310		

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OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER TWIN FALLS CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 674 EASTLAND DRIVE TWIN FALLS, ID 83301		
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F 310	<p>Continued From page 29</p> <p>abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's ability to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure 1 of 15 sampled residents (#8) was provided oral care. This failure created the potential for a decline in activities of living and the potential for emotional distress and decreased socialization from unmet needs. Findings included:</p> <p>Resident #8 was admitted to the facility on 11/23/11 with diagnoses that included Unspecified Intellectual Disabilities and Manic Disorder.</p> <p>The resident's Care Plan included the following problem area, with an onset date of 1/10/11 and with a goal date of 10/22/14: Self Care Deficit r/t (related to) cognitive impairment, weakness. Goals: "Will participate in ADL's daily and have a neat, clean, well groomed appearance." Intervention: " Oral cares BID [two times a day] and PRN [as needed]."</p> <p>On 9/23/14 at 8:16 AM, 8:25 AM, and 1:42 PM and on 9/24/14 at 10:34 AM and 11:15 AM, Resident #8 was observed to have un-brushed teeth, a large accumulation of white matter around her teeth, and inflamed looking upper gums. When the surveyor asked the resident</p>	F 310	<p><u>Systemic Changes</u></p> <p>Nursing staff were educated by the Director of Nursing or designee on or before 11/7/14 regarding providing oral care to residents, including scheduling dental appointments if needed.</p> <p><u>Monitoring</u></p> <p>Starting the week of 11/10/14, an audit of 5 residents will be completed by the Director of Nursing or designee weekly x 4 weeks and then monthly x 2 months to ensure oral care is provided to residents per the plan of care and that dental appointments are scheduled if needed. Results of the audits will be reported to the Performance Improvement Committee for three months for review and remedial intervention. The Director of Nursing is responsible for monitoring and compliance. The Performance Improvement Committee will re-evaluate the need for further audits after 3 months.</p> <p><u>Date of Compliance</u></p> <p>11/7/14</p>		

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

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F 310	Continued From page 30 about brushing her teeth she stated, "I brush my teeth when I get up, [I have] no cavities." On 9/23/14 at 4:30 PM the surveyor informed the DON of the observations and asked if the resident has had a dentist visit recently. He stated, "I don't know, I will look into that." On 9/24/14 at 2:21 PM, the DON stated, "[Resident #8] has not had a dentist appointment, but we will make one for her." On 9/24/14 6:30 PM, the Administrator and DON were informed of the issue. No further information was provided.	F 310			
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: Based on record review and staff interview, it was determined the facility failed to assess a resident that was frequently incontinent to determine if toilet training would benefit her. This was true for 1 of 13 (#5) sampled residents. There was a potential for harm to the resident due to a loss of bladder function and the	F 315	<u>F-315</u> <u>Specific Residents Identified</u> Resident #5 has been discharged from the facility. <u>Identification of Other Residents</u> Residents who are incontinent of bladder have been assessed by the Director of Nursing or designee on or before 11/7/14 to determine if toilet training would benefit them. Resident care plans have been reviewed and updated by the Director of Nursing or designee on or before 11/7/14 to reflect the current condition for those residents needing assistance and/or with a toileting plan.		

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F 315	<p>Continued From page 31</p> <p>secondary effects of incontinence. Findings include:</p> <p>Resident #5 was admitted on 7/26/14 with diagnoses of rehabilitation, hemiplegia affecting unspecified side due to cerebrovascular disease and aphasia due to cerebrovascular disease.</p> <p>The resident's 8/1/14 admission MDS assessment documented the resident: *was frequently incontinent of bowel and bladder; *required extensive assistance for transfers, dressing, toilet use, personal hygiene and bathing; and, *was severely cognitively impaired, with a BIMs of 5.</p> <p>The resident's Self Care Deficit care plan, dated 7/28/14, documented a handwritten and undated intervention of, "Inc[ontinent] B&B [bowel and bladder]-staff to offer toilet q[every] 2 [hours] & prn."</p> <p>An undated and unsigned Bowel and Bladder Continence Evaluation form was reviewed in the resident's medical record. The document contained a 72 hour voiding diary with dates 7/26/14 through 7/29/14. The diary contained boxes for each hour of the day to code with the resident's voiding patterns. On 7/27 and 7/28/14 the boxes from 3 PM through 10 PM and 7/26 and 7/28/14 from 11 PM through 6 AM, were left blank. The form contained a section which documented, "Based on the evaluation, check the type of program and state reason for choice..." Next to the section were choices of Bladder Re-Training, Prompted Voiding, Scheduled Voiding, and Check and Change. A check box appeared next to each choice, however, none of</p>	F 315	<p><u>Systemic Changes</u></p> <p>Nursing staff has been educated on or before 11/7/14 by the Director of Nursing or designee regarding completion of bladder assessments and toileting plans including need to care plan current status.</p> <p><u>Monitoring</u></p> <p>Beginning the week of 11/10/14, audits of 5 bladder assessments will be completed by the Director of Nursing or designee weekly x 4 weeks and then monthly x 2 months to ensure that the current toileting plans of the residents' are accurate. A report will be submitted to the Performance Improvement Committee monthly for 3 months for review and remedial intervention. The PI Committee will re-evaluate the need for ongoing audits after 3 months. The Director of Nursing is responsible for monitoring and compliance.</p> <p><u>Date of Compliance</u></p> <p>11/7/14</p>

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F 323	<p>Continued From page 33</p> <p>devices not assessed as safe for their individual needs. Resident #6 was harmed when she fell and sustained a left hip fracture in the facility and required surgical intervention. Findings included:</p> <p>1. Resident #6 was admitted to the facility from the acute care hospital on 7/7/14, following a fall at home with rib fractures and a history of alcohol abuse, CAD and CHF.</p> <p>Resident #6's MAR documented the resident received Lasix 40 mg at 6:00 AM daily, between 7/7/14 and 7/12/14. The medication was documented as refused on 7/13/14.</p> <p>The record between 7/7/14 and 7/13/14 documented a Fall Risk Evaluation with a score of 21. The form had no specific date of completion, but documented the resident was at high risk for falls.</p> <p>On 7/12/14 at 4:35 PM, Resident #6's Nurse's Progress Notes (PNs) documented, "...Visitor stated she gave resident a bottle of wine, approx[imately] 6 [ounces]. Res[ident] drank this bottle of wine. Res[ident] appears to be having [signs and symptoms] of withdrawal. Res[ident] is shaking and mumbling..."</p> <p>On 7/13/14 at 7:00 AM, Resident #6's PNs documented, "Resident [with] increased tremors and mumbling which was reported by evening shift...Resident able to state year, month, and her name...Resident to [acute care hospital] per ambulance..."</p> <p>On 7/13/16, Resident #6 was discharged to the acute care hospital. Her H&P from that date documented new diagnoses of acute</p>	F 323	<p><u>Identification of Other Residents</u></p> <p>A review of residents determined to be at risk for falls based on their fall risk assessment score has been completed by the Director of Nursing or designee on or before 11/7/14 to ensure that fall risk assessments are complete, the care plan reflects resident risk factors including side effects of medication and alcohol use and that current interventions to prevent falls address resident risk factors. A facility round was completed by the Director of Nursing or designee on or before 11/7/14 to ensure that care planned interventions are implemented at the bedside. Any findings were corrected by the Director of Nursing or designee on or before 11/7/14. Updates will be made by the Director of Nursing or designee on or before 11/7/14. An audit of residents with restrictive devices including seat belts and side rails has been completed by the Director of Nursing or designee on or before 11/7/14 to ensure that a safety assessment was completed. Findings were corrected. Follow up assessments were completed by the Director of Nursing or designee on or</p>	

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

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F 323	<p>Continued From page 34</p> <p>encephalopathy, altered mental status, and acute kidney injury. The resident remained in the acute care hospital until 7/16/14, when she was re-admitted to the facility.</p> <p>Resident #6's Physician's orders for her re-admission to the facility on 7/16/14 did not include the previously ordered Lasix, or other diuretic medications. The orders did document the resident could have 5 ounces of wine with dinner and at bedtime (6:00 PM and 9:00 PM).</p> <p>On 7/17/14, Resident #6's care plan documented: **Self Care Deficit anxiety, depression, physical limitations, weakness." Interventions included one person assistance with ADLs, transfers, bed mobility; and to adjust the level of care according to her individual needs. **Risk for falls related to: unsteady gait, pain, history of multiple falls, generalized weakness, decreased safety awareness, anxiety." Interventions directed staff to reinforce the need to call for assistance, and to encourage the resident to communicate needs and ask for assistance. *The care plan did not document the use of diuretic medication, nor did it include a toileting care plan to maintain continence. *The care plan did not document the use of wine for the resident, her history of obtaining additional wine beyond what was ordered, that she had recently required medical detoxification from alcohol use, nor any additional monitoring to be performed after she had consumed alcohol.</p> <p>On 7/23/14 Resident #6's Admission MDS coded the resident was cognitively intact. However, the instructions further documented, "The BIMS is a brief screener that aids in detecting cognitive</p>	F 323	<p>before 11/7/14. A round of the facility was completed by the Administrator on 10/20/14 to ensure that nurses medication carts were not blocking the hand rails with no issues noted. The carts were not blocking the hand rails on either side of room 401 or room 403.</p>	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 323	<p>Continued From page 35 impairment. It does not assess all possible aspects of cognitive impairment..."</p> <p>The 7/23/14 MDS further coded: *Limited assistance of one for bed mobility, transfers, dressing, toilet use, and personal hygiene; *Extensive assistance of one for ambulation; *Continent of bowel and bladder; *Balance unsteady, only able to stabilize with staff assistance when moving from a seated position to standing, walking, turning, moving on and off the toilet, and surface-to-surface transfers; and *History of falls before admission.</p> <p>On 7/23/14, Resident #6's CAAs documented: *ADLs - "[Resident #6] has been in the hospital to detox from her [alcohol] abuse. She does require up to extensive assistance with...ambulation...up to limited assistance with...transfers...toileting, personal hygiene..." *Urinary Incontinence - Pertinent medications were documented as anticholinergics, antidepressants and sedatives. Diuretics, which can cause urge incontinence, were not marked as a factor at that time. *Falls - "[Resident #6] has had previous falls from her [alcohol] abuse...she is at further risk for falls due to her daily use of antidepressants...she also takes an antianxiety medication..." Interventions included placing the resident in a room close to the nurse's station, reinforcing the need to call for assistance, and encouraging the resident to communicate needs and ask for assistance.</p> <p>Beginning 7/23/14, Resident #6's PNs began to note changes in her edema levels, oxygen saturations, weight, and lung sounds. Please see F 309 for details of these changes.</p>	F 323	<p><u>Systemic Changes</u></p> <p>Licensed nursing staff have been educated by the Director of Nursing or designee on or before 11/7/14 regarding completion of fall risk assessments, identifications of resident risk factors for falls including medications and alcohol use and interventions for fall prevention on the plan of care and implemented at the bedside and hand rails being accessible to residents ensuring medication carts are not blocking the hand rails. Ensure documentation of monitoring as required. Licensed nursing staff have been educated by the Director of Nursing or designee on or before 11/7/14 regarding completion of device evaluations which is to include safety assessments for side rails and seat belts. Interdisciplinary Team, therapy staff and licensed nurses educated by the Director of Nursing or designee on or before 11/7/14 regarding proper communication and use of communication forms.</p>	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 323	Continued From page 36 On 7/25/14, Resident # 6's care plan was updated to include focus areas of her desire to return to her home in the community, and for feelings of sadness. No further care plan updates were noted until 8/11/14. On 7/29/14, Resident #6 was again discharged from the facility to the acute care hospital. Her H&P for that date documented new diagnoses of acute heart failure with fluid overload, COPD exacerbation, and macrocytic anemia. On 8/2/14, the resident was re-admitted to the facility. Her admission physician's orders documented the resident received 40 mg of Lasix twice daily, at 10:00 AM and 6:00 PM, as well as 5 ounces of wine at 6:00 PM and 9:00 PM. [NOTE: The resident had received 40 mg of Lasix at 6:00 AM only, no evening dose, between 7/7/14 and 7/12/14. She had not been on diuretic medication in the facility since that time.] No care plan updates were noted related to her new diagnoses, how her recent illnesses may increase her risk for assistance with ADLs or falls, nor how the use of diuretic medication may increase her frequency for toileting assistance. On 8/2/14 at 10:00 PM, Resident #6's PNs documented, "Resident...re-admitted to this facility following a hospitalization to receive care for various [diagnoses]...continent of [bowel and bladder], but prefers to wear Poise pads for protection...She is [alert and oriented to person, place, and situation with] mild forgetfulness noted [at] times..." No care plan updates were noted regarding the	F 323	<u>Monitoring</u> Starting the week of 11/10/14, audits of 5 residents will be completed by the Interdisciplinary Team as assigned by the administrator, of residents with falls 2 x week x 4 weeks and then weekly x 2 months to ensure fall assessments are complete, risk factors are identified and prevention interventions are in place and care plans reflect current interventions. Starting the week of 11/10/14 audits of 5 residents will be completed by the Director of Nursing or designee weekly x 4 weeks and then monthly x 2 months of residents with seat belts and side rails to ensure completion of device evaluations to include a safety assessment prior to implementation. Starting the week of 11/10/14, facility rounds will be completed by the Administrator or designee weekly x 4 weeks and then monthly x 2 months to ensure that the hand rails are readily accessible to the residents. Results of the audits will be reported to the Performance Improvement Committee monthly for 3 months for review and remedial intervention. The Director of Nursing is responsible for monitoring and compliance. The Performance Improvement Committee will re-		

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F 323	<p>Continued From page 37</p> <p>resident's forgetfulness, nor that the resident was now using an incontinence product.</p> <p>On 8/2/14, Resident #6's MAR documented she received both scheduled doses of Lasix, as well as both allotted glasses of wine.</p> <p>On 8/3/14 at 5:30 PM, a facility Accident and Incident report (I/A) for Resident #6 documented, "Resident was ambulating to the bathroom with walker, went to go open the door to the bathroom, and let go of the walker. The resident then lost her balance and fell on her left side... BIMS was 13 upon return BIMS was 15. Resident was aware she that she should not have been ambulating without assistance." Probable root cause was documented as, "Poor safety awareness, COPD, lost balance before LN could get to her." New interventions included, "increased supervision, encouraged to use call light, ask for assistance..." An attached statement from the CNA documented, "...When she fell I was helping getting someone up for dinner. I was on the floor by myself when she fell..." The I/A report included a Fall Risk Evaluation dated 8/3/13, with a score of 23. A hand-written addendum to the form documented, "23 was post-fall. Res[ident] was 14 prior to fall." The form documented scores 12 or greater indicated high fall risk.</p> <p>The I/A included a signed statement from Resident #6, dated 8/3/14 at an unknown time, which documented, "I fell while getting to the bathroom with no help. My fault. Not use call light."</p> <p>The I/A did not address what the facility was doing to address the forgetfulness noted in the</p>	F 323	<p>evaluate the need for further monitoring after 3 months.</p> <p><u>Date of Compliance</u></p> <p>11/7/14</p>		

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F 323	<p>Continued From page 38</p> <p>8/2/14 PN, or her poor safety awareness. The I/A also did not address when the resident was last assisted to the toilet. The I/A did not document if the resident had received her Lasix and/or wine before or after the fall. Additionally, the I/A did not address the CNA statement that s/he was the only CNA working on the hall at that time.</p> <p>On 8/3/14 at 10:22 PM, an x-ray report for Resident #6 documented a left femoral neck fracture. The resident was sent to the acute care hospital and admitted for surgical repair of the injury.</p> <p>On 9/23/14 at 9:30 AM, the surveyor observed Resident #6 alone in her room, sitting in her wheelchair at the foot of her bed. The call light was not on. The resident grabbed the foot board of the bed, used it to pull herself to a standing position, shuffled approximately 4 steps to the window, adjusted the blinds, then returned to and sat in her wheelchair. When interviewed, the resident recalled her fall, stating, "I thought I could get from point A to point B, but I didn't make it." The resident said she was aware she should have someone help her whenever she needed to get up, and stated, "I would never make that mistake again. If I need to get up, I ask for help." Only when prompted did the resident recall she had just stood from her wheelchair unassisted to adjust the blinds.</p> <p>On 9/23/14 at 1:10 PM, the MCO and HIM (Health Information Manager) were asked to provide a copy of the care plan in place at the time the resident fell on 8/3/14. The MCO stated since the resident had previously been in the facility, was known to the staff, and had been in the facility for "less than 24 hours" when she fell,</p>	F 323			

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

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F 323	<p>Continued From page 39</p> <p>the facility had been using the care plan in place at the time the resident discharged to the acute care hospital on 7/29/14.</p> <p>On 9/23/14 at 4:15 PM, Resident #6 was asked about her written statement regarding the fall. The resident did not recall writing the statement, nor when it was written, but stated, "That's my signature. I must have written it." The resident then looked away from the surveyor and repeated twice, in a quiet voice, "It's my fault. It's my fault."</p> <p>On 9/24/14 at 11:15 AM, the DNS and MCO were interviewed regarding the resident's fall. The DNS stated the facility had determined the root cause of the resident's fall to be that the resident was taking herself to the bathroom without asking for assistance. The DNS stated, "She was alert and oriented. She chose to get up without help. She had a BIMS of 13 when she first came, and it was a 15 when she came back on the 2nd." The DNS stated the facility had not assessed the resident's cognition directly, but had received word from the hospital of her BIMS score. The DNS could not provide documentation from the hospital regarding the score. The DNS stated the resident's fall risk had been assessed as a "14" prior to her fall, which was "barely" at high risk for falls. The DNS stated it would not be unusual to have only 1 CNA working the floor at that time of day, due to the need to provide breaks. The DNS stated, "They have to take their breaks between 2:00 and 5:00 in the afternoon." The DNS stated he would need to investigate further to determine what other fall interventions were in place, whether or not the resident had wine before she fell, when she was last given Lasix, when she was last taken to the toilet, and whether availability of staff at that time had been a factor</p>	F 323		

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135104	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/26/2014
NAME OF PROVIDER OR SUPPLIER TWIN FALLS CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 674 EASTLAND DRIVE TWIN FALLS, ID 83301		
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F 323	<p>Continued From page 40</p> <p>in the resident's "choice" to go to the bathroom without assistance.</p> <p>On 9/25/14 at 10:20 AM, the DNS and MCO approached stated they did not find any additional documentation regarding the events leading up to the resident's fall. They stated in general, during her previous admissions to the facility the resident had appeared to be alert and oriented, and asked for assistance appropriately. The DNS stated when re-admitted for the third time on 8/2/14, the facility's documentation indicated the resident had no changes in cognition, therefore the facility felt it could utilize the same care plan in place previously. The DNS stated the facility had addressed the resident's decreased safety awareness identified as a risk factor on the 7/17/14 care plan by moving the resident to a room closer to the nurse's station, although he was uncertain when this move had taken place. Otherwise, the DNS stated the facility felt the facility's plan had been successful, as the resident had not fallen. The DNS stated the facility was focused on increasing resident independence, and for this resident in particular, this meant treating her "like everyone else" in light of her alcohol abuse history. The DNS stated the resident would not necessarily have a care plan to address her toileting needs "unless she had demonstrated non-compliance or had a change in risk factors other than medication." The DNS stated the facility did not consider the use of a diuretic medication as a risk factor for this resident as she had taken it in the past. [NOTE: The resident had not been on that medication (Lasix) since at least 7/16/14. Since that time, she had developed an exacerbation of COPD, which required hospitalization and IV diuretics to treat. The resident's dose of Lasix on 8/2/14 was twice</p>	F 323		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135104	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/26/2014
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F 323	<p>Continued From page 41</p> <p>what she had previously received, and was administered at 10:00 AM, rather than 6:00 AM, as well as 6:00 PM.] The DNS was unable to provide information as to when the resident had last been toileted before her fall, and whether she had received her evening dosage of Lasix and/or a glass of wine before the fall. The DNS and MCO stated they did not feel the facility should have implemented additional supervision for the resident when she returned to the facility because she had usually asked for help before, and had not shown evidence of cognitive deficits.</p> <p>Resident #6 was harmed when the facility failed to identify risks and provide necessary assistance and supervision to avoid falls with injury.</p> <p>On 9/26/14 at 10:00 AM, the Administrator, DNS, and CMO were informed of these findings. The facility offered no further information.</p> <p>2. The State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities at F 323 documented, "In 1995, the FDA issued a Safety Alert...Residents most at risk for entrapment are those who are frail or elderly or those who have conditions such as agitation, delirium, confusion, pain, uncontrolled body movement, hypoxia, fecal impaction, acute urinary retention, etc. that may cause them to move about the bed or try to exit from the bed. The timeliness of toileting, appropriateness of positioning, and other care-related activities can contribute to the risk of entrapment."</p> <p>a. On 8/8/14, Resident #6's record documented a Restrictive Device Consent for one-quarter side rails on both sides of her bed.</p>	F 323		

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

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

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F 323	<p>Continued From page 42</p> <p>On 9/23/14 at 8:05 AM, the resident was observed in her bed, with the quarter side rails both up. The side rails were observed again in the upraised position on 9/23/14 at 9:30 AM and 4:15 PM.</p> <p>b. Resident # 1 was admitted to the facility on 7/14/14 with multiple diagnoses which included ESRD, DM, and bilateral BKAs.</p> <p>On 9/24/14 at 2:30 PM, Resident # 1 was observed lying in his bed, with two half side rails in the upraised position. The resident stated he used the siderails to move in bed, since he had "no legs."</p> <p>On 9/25/14, the DNS and RDCO were asked to provide documentation the above devices were assessed as safe for the residents to use; this documentation was not provided.</p> <p>**Resident #16 was admitted to the facility on 5/6/14 with diagnoses that included adult failure to thrive, muscular wasting and disuse atrophy, dysphagia oral phase and other specified rehabilitation.</p> <p>The resident's care plan for Risk of Falls dated, 5/7/14 documented interventions that included low bed, resident to wear nonslip footwear, reinforce the need to call for assistance.</p> <p>The resident's Fall Risk Evaluation dated 5/8/14 assessed the resident to be at "high" risk for falls with a score of 13. A second evaluation without a date assessed the resident at "High" risk with a score of 18.</p>	F 323		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135104	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/26/2014
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F 323	<p>Continued From page 43</p> <p>The resident's I & A (Incident and Accident) form dated 5/8/14 documented the resident had a fall while the therapist assisted the resident back to bed. The therapist had turned away from the resident and she slid from her w/c (wheel chair). The probable root cause was the resident had poor safety awareness and a recent decline in her condition. New interventions to be put in place were strict observation when up in the w/c and for the resident to remain in the line of sight of the staff.</p> <p>The resident's Therapy Communication to Nursing dated 5/9/14 documented, "Patient found in room attempting to self (transfer) to get to the bathroom this AM & was discovered 1/2 on bed 1/2 off bed by CNA." The problem identified was, "Patient at risk for falls (secondary) to self-(transferring) to get into the bathroom." The recommendations were, "Alarm on bed," and precautions were, "urination urgency."</p> <p>The resident's Care plan for Risk for falls was updated on 5/15/14 to include, nursing to ensure that the resident is not to be left alone when assisting with toileting needs, related to history of self transfers, decreased safety awareness. NOTE: The new intervention was not documented on the care plan til 6 days after the the resident was found 1/2 out of bed due to the need to urinate.</p> <p>On 9/24/14 the DON provided 1/2 hour checks sheets that were implemented on the resident on 5/9/14 and continued on 5/10/14. On 5/11/14 from 6:00 AM until 10:00 PM, the resident was checked every hour and from 10:00 PM until 5:00 AM, the resident was checked every half hour. The fourth check sheet provided without a date,</p>	F 323		

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

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

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F 323	<p>Continued From page 44</p> <p>did not document the resident was checked from 6:00 AM until 2:00 PM. From 2:00 PM until 3:00 AM, the resident was checked hourly. NOTE: The checks were not documented on the resident's care plan for falls.</p> <p>On 9//23/14 at 3:35 PM, the DON was asked when nursing received the Therapy Communication to Nursing form dated 5/9/14, would there have been changes in the resident care, and he stated, "It depends." He was asked if he was notified when this form was provided to nurse staff. The DON stated, "Probably not," it would go to the Nurse Manager or Unit Coordinator. He stated he would look into it.</p> <p>On 9/24/14 at 9:25 AM, the DON stated he had asked the nurses about the Communication form and they did not remember anything about it. He was asked if the form had been filed in the chart and staff not notified, he stated, "I am not going to tell you that I am not going to go to the Occupational Therapy Supervisor and talk about it. I am going to tell you she did not fall again."</p> <p>On 9/24/14 at 12:30 PM, the Administrator, DON and MCO were notified of the findings. No additional information was provided.</p> <p>2. Resident #3 was admitted on 6/9/13 with a diagnosis of Huntingtons Chorea and Dementia.</p> <p>Physician's order dated 6/9/13, " Releasing seat belt while in w/c [wheelchair] d/t [due to] decreased safety awareness and decreased control of body mechanics..."</p> <p>Device Evaluation dated 7/22/13 and Quarterly</p>	F 323		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135104	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/26/2014
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F 323	Continued From page 45 evaluation dated 7/10/14 failed to have an assessment completed to ensure the seatbelt did not pose a safety risk for the resident. On 9/24/14 at 2:21 PM, DON was interviewed related to Resident #3's Device Evaluation not having an assessment of safety he stated, " It's not there." 3. On 9/23/14 from 1:45 PM to 3:35 PM, the 400 hall medication carts were observed to be blocking the handrails on both sides of room 401's door. On 9/24/14 from 10:15 AM to 11:15 the 400 hall medication carts were observed to be blocking the handrails between room 401 and the 400 hall medication room. From 3:00 PM to 3:30 PM the medication carts were observed to be parked outside room 403, blocking the handrails, on both sides of the door. On 9/25/14 at 1:35 PM, the DON was asked about the medications carts blocking the handrails he stated, "the staff have direction to keep the carts off the most used areas. The residents usually cut accross. The staff is directed to have no carts in the short hall and none in the day room, ever. We can re-look at it, is there a issue with that."	F 323			
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident -	F 325			

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

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

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F 325	<p>Continued From page 46</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to immediately initiate interventions before a resident experienced weight loss. This affected 2 random residents (#'s 16 & 18), reviewed for weight status. Resident #18 experienced weight loss during the second week after admission and Resident #16 was at risk for weight loss due to lack of implementation of RD recommendations. This practice created the potential for residents to experience compromised nutritional status. Findings included:</p> <p>1. Resident #18 was admitted to the facility on 8/21/14 with multiple diagnoses which included personal history of fall, abnormality of gait, chronic respiratory failure, muscular wasting and disuse atrophy.</p> <p>The August 2014 All Active & Discontinued Orders (recapitulation) documented the following: *Regular/liberalized diet; and, *Weigh weekly, Day Shift, Saturday.</p> <p>The resident's Admission MDS Assessment, dated 8/28/14, documented the resident was unable to complete the Brief Interview for Mental</p>	F 325	<p><u>F325</u></p> <p><u>Specific Residents Identified</u></p> <p>Residents #16 and #18 have been discharged from the facility.</p> <p><u>Identification of Other Residents</u></p> <p>An audit of residents' weights has been completed on or before 11/7/14 by the Registered Dietician to ensure significant weight losses were addressed with interventions and dietician recommendations implemented timely per physician orders and care plans updated as needed. Any findings were corrected by the Director of Nursing or designee on or before 11/7/14.</p> <p><u>Systemic Changes</u></p> <p>The Licensed Nurses were educated by the Director of Nursing on or before 11/7/14 regarding interventions to prevent weight loss and implementation of dietician recommendations and physician notification and implementation of orders timely.</p>	

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

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F 325	<p>Continued From page 47</p> <p>Status, needed supervision with set up help, height 61" and weight 171 pounds.</p> <p>The resident's 8/26/14 Nutrition Care Plan documented the following goals: **Will not have significant change in weight of 5% in 30 days or 10% in 180 days. *Consumes greater than or equal to 60% of most meals." The 8/26/14 interventions included, "...Encourage fluids throughout the day, snacks available PRN, monitor weight and PO intake routinely." Interventions were added on: **9/9/14 - Assisted dining room for cueing/assistance as needed; and, *9/11/14 - Ice cream with dinner."</p> <p>The Weights and Vitals Summary documented the resident weighed: *171# (pounds) on 8/21/14, date of admission; *171# on 8/26/14; *161# on 9/2/14; *155.5# on 9/8/14; and, *167# on 9/16/14.</p> <p>On 9/23/14 at 3:55 PM, the RD was shown the resident's Weights and Vitals Summary and stated she assessed the resident on 8/25/14. The RD referred to her Progress Notes, dated 9/4, 9/9 & 9/11 of 2014, when asked specifically regarding the resident's 10 pound weight loss in one week. The RD stated she spoke with the resident's caregiver at the previous residence regarding his weight history. The caregiver told the RD the resident's usual body weight was 165-175 pounds and had been in that range since November 2013. The RD continued to obtain weekly weights and follow up with interventions as appropriate. The RD stated that on 9/8/14 the resident's</p>	F 325	<p><u>Monitoring</u></p> <p>Starting the week of 11/10/14, the Registered Dietician and Director of Nursing will audit 5 resident weights weekly for 3 months to ensure that significant weight loss continues to be identified with dietary recommendations and interventions implemented per physician orders timely and care plans updated. Results of audits will be reported to the Performance Improvement Committee monthly for 3 months for review and remedial intervention. The Registered Dietician and Director of Nursing are responsible for monitoring and compliance. The Performance Improvement Committee will re-evaluate the need for further monitoring after 3 months.</p> <p><u>Date of Compliance</u></p> <p>11/7/14</p>	

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

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F 325	<p>Continued From page 48</p> <p>weight had dropped to 155.5 pounds, which was a 9.1% weight loss since admission. When asked what contributing factors for weight loss had been attributed to, the RD stated it was due to decreased oral intakes and believed the resident's dentures were ill-fitting. The RD stated she recommended a diet change to "dysphagia advanced" due to chewing problems and moved the resident to the assisted dining room for cueing and assistance with meals. She also recommended the resident be seen by someone who could help him with proper fitting dentures. The RD stated that on 9/11/14 she recommended monitoring the resident's weight daily and for nursing staff to notify her of a minus 3 or plus 3 pound weight change. The RD stated the resident's weight stabilized at 167 pounds once the resident was moved to the assisted dining room. When asked why it took a 15.5 pound weight loss in 13 days before interventions were put in place, the RD could not provide an explanation.</p> <p>On 9/23/14, at 4:25 p.m., the DON stated the weight loss was due to the resident being "sick, very sick" with pneumonia, urinary tract infection, and delirium with hallucinations.</p> <p>On 9/24/14 at 12:30 PM, the Administrator, MCO and DON were made aware of the concern regarding weight loss. No further information was provided by the facility which resolved the issue.</p> <p>2. Resident #16 was admitted to the facility on 5/6/14 with diagnoses that included adult failure to thrive, muscular wasting and disuse atrophy, dysphagia oral phase and other specified</p>	F 325		

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

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F 325	<p>Continued From page 49 rehabilitation.</p> <p>The resident's physician admission orders, dated 5/6/14, documented the resident was to have a "Supplement per your dieticians [sic] recommendations." The resident's additional physician order, dated 5/13/14, documented, "House supplement for daily every day."</p> <p>The resident's Medical Nutrition Therapy Assessment, dated 5/8/14, completed by the RD (Registered Dietitian), documented: The resident's usual weight was 140 pounds, admission weight was 115 pounds and ideal body weight goals were 110 plus or minus 10 pounds. The resident had slow weight loss over the previous 4 years and received a dysphagia, puree diet with nectar thick liquids. Her husband stated she had never been a big eater. The physician tried several appetite stimulants without success. The plan included monitoring weight and oral intake, and providing "comfort" snacks and the House supplement daily.</p> <p>The resident's Dietary/Nursing Nutritional Care Recommendation form, dated 5/8/14 and completed by the RD, documented the RD recommended House Supplement daily; once an order was received it was to be added to the nutrition care plan.</p> <p>The resident's Nutrition care plan on 5/8/14 documented the resident was to receive "comfort" snacks provided by dietary per the resident's preferences; this was changed to twice a day on 5/15/14. On 5/13/14, the care plan was updated to add a Health shake every day at 10:00 AM. NOTE: The Health shake was added to the care plan 7 days after the RD's recommendation.</p>	F 325		

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

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F 325	<p>Continued From page 50</p> <p>The RD's IDT (Interdisciplinary Progress Note), dated 5/13/14 at 3:50 PM, documented the family was concerned about the resident's weight and was bringing Frosty ice cream most days.</p> <p>A physician's order, dated 5/13/14, documented the resident was to receive a House supplement daily.</p> <p>The facility weight record documented the resident's weight in pounds as: 5/7/14- 115.0, 5/12/14- 104.0, 5/13/14- 104.5, 5/19/14- 109.0, 5/23/14 -108.5. NOTE: The resident had an 11 pound drop in weight from 5/7/14 to 5/12/14.</p> <p>On 9/23/14 at 2:45 PM, the DM (Dietary Manager), and RD, with the RDFN (Regional Director of Food and Nutrition) present, were asked to describe the RD recommendations process. The RD stated she makes the recommendation, which then goes on the communication form. The DM and UM (unit Manager) then get a copy of the form, and finally the nurses get an order for the recommendation and give it to the DM. The surveyor asked why the recommendation for the House supplement was not started until 5/13, which was 5 days after the recommendation. The RD stated, "That would be a nursing question."</p> <p>On 9/23/14 at 3:35 PM, the DON was asked why it took 5 days to get an order for the House supplement, and why the resident experienced a weight loss after admit to the facility.</p> <p>On 9/24/14 at 9:25 AM, the DON with the MCO (Medical Coordinator of Operations.) present,</p>	F 325		

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

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F 325	Continued From page 51 was asked if the resident should have been reweighed when there was an 11 pound weight loss. The DON stated, "Yes," and it was the facility's policy to re-weigh, but, "We screwed up." He stated the process was for the RNA (Restorative Nurse Aide) to report the weight to the UM or UC (Unit Coordinator), who would then request the re-weigh. The DON stated, "I don't disagree with you we have problems with our weights." The DON verified Nursing received the RD recommendation on 5/8/14, and stated, "I can't provide evidence, but I can tell you they did it." On 9/24/14 at 12:30 PM, the Administrator, MCO and DON were informed of the findings. No additional information was provided.	F 325		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure residents who used oxygen:	F 328		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135104	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/26/2014	
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F 328	<p>Continued From page 52</p> <p>*received the liter flow as ordered by the physician;</p> <p>*had the order on the physician's recapitulation orders or MAR for oxygen; and,</p> <p>*had orders for a resident's use of a CPAP machine. This was true for 1 of 5 sampled residents (#2) and 1 random resident (#18), reviewed for oxygen therapy and created the potential for harm should residents receive oxygen therapy at different concentrations than ordered by the physician. Findings included:</p> <p>1. Resident #2 was admitted to the facility on 7/16/14 and readmitted on 9/12/14 with multiple diagnoses including congestive heart failure and dependence on machine for supplemental oxygen.</p> <p>The resident's 9/12/14 Admission Orders documented, "3-4 L[iters] NC [Nasal Cannula]." Note: The orders did not document if the oxygen was to be administered continuous or PRN and when to use 3 or 4 liters.</p> <p>The resident's Admission Nursing Assessment, dated 9/12/14, documented the resident received oxygen at 4 liters per minute.</p> <p>A physician's progress note dated 9/14/14 documented under History of Present Illness, "1. Acute on chronic hypoxic respiratory failure which improved." and under Current Medications, "6) OXYGEN 3 liters per nasal canal [sic] continuous for COPD [Chronic Obstructive Pulmonary Disease]...CHF [Congestive Heart Failure]..." The resident's care plan, dated 9/23/14, documented: *Focus-"COPD-Clinical Management and chronic respiratory failure."</p>	F 328	<p><u>F-328</u></p> <p><u>Specific Residents Identified</u></p> <p>Oxygen and CPAP orders for Resident #2 have been reviewed by his physician on or before 11/7/14 and his care plan and Medication Administration Record updated by the Director of Nursing or designee to accurately reflect the physician order.</p> <p>Resident #2 was assessed by the Director of Nursing or designee on or before 11/7/14 for any signs or symptoms of adverse effect or respiratory distress. Findings will be reviewed with the physician and resident/family notified as indicated.</p> <p>Resident #18 has been discharged from the facility.</p>	

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F 328	<p>Continued From page 53</p> <p>*Intervention-"Administer Oxygen as ordered/indicated."</p> <p>The resident's September Recapitulation orders and MAR, dated 9/12/14, did not include Oxygen as part of either record.</p> <p>The following observations were conducted: -9/23/14 at 9:20 AM, the resident was observed in his bed with a nasal cannula on and the oxygen concentrator was set for 3 liters; -9/23/14 at 12:08 PM, the resident was observed in his wheelchair in the dining room with a nasal cannula on and his oxygen tank was set for 2 liters; -9/23/14 at 3:15 PM, the resident was observed in his bed with a nasal cannula on and the oxygen concentrator was set for 3 liters; and, -9/24/14 at 10:30 AM and 2:15 PM, the resident was observed in his bed with a nasal cannula on and the oxygen concentrator was set for 3 liters.</p> <p>On 9/24/14 at 5:40 PM, the DON and MCO were interviewed regarding the recapitulation and MAR issues and the observations with the two different liter flows. The MCO said she thought they had reviewed all residents in the building for oxygen issues and said she and the DON would look into the issue for Resident #2.</p> <p>On 9/25/14 at 3:45 PM, the Administrator, DON and MCO were informed of the oxygen issue. No further information was provided by the facility. 2. Resident #18 was admitted to the facility on 8/21/14 with multiple diagnoses which included chronic respiratory failure, obstructive sleep apnea and dependence on machine for supplemental oxygen.</p>	F 328	<p><u>Identification of Other Residents</u></p> <p>A review was completed by the Director of Nursing or designee on or before 11/7/14 of physician orders of current residents with oxygen orders and orders for CPAP machines and physician orders compared to the treatment administration record to ensure that the orders are clarified and being followed as written. Any findings were corrected by the Director of Nursing or designee on or before 11/7/14.</p> <p><u>Systematic Changes</u></p> <p>Licensed nurses have been educated by the Director of Nursing or designee on or before 11/7/14 regarding accurately following physician orders for oxygen and CPAP machines and accurately documenting implementation of those orders.</p>	

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

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F 328	<p>Continued From page 54</p> <p>An 8/20/14 Progress Note documented, "Accept as Admitting H & P... Obstructive Sleep Apnea...continue with his CPAP device at the skilled nursing facility."</p> <p>An Inventory of Personal Effects on admission documented the resident was admitted to the facility with his CPAP machine.</p> <p>The resident's All Active & Discontinued Orders for August 2014 did not include an order for CPAP. However, a 9/4/14 All Active Order included to wash the CPAP mask daily, to clean the CPAP tubing weekly and to clean the "headgear" as needed. Additionally, the order documented, "Wear CPAP at night. May use personal CPAP from home. Night Shift, Evening Shift Everyday."</p> <p>A Progress Note, dated 9/4/14 at 2:45 PM, documented, "CPAP at HS (hour of sleep) as ordered."</p> <p>A Physician Orders sheet, dated 9/5/14, hand written by the physician, documented, "Be sure patient uses CPAP @ HS."</p> <p>A Summary View Family Conference Progress Note, dated 9/5/25, by the resident's physician, documented under Treatment, "...Obstruct sleep apnea...Patient is to wear his CPAP device at night...Patient needs to continue on his CPAP device and oxygen supplementation."</p> <p>A Progress Note, dated 9/6/14 at 7:30 AM, documented, "Resident alert, encouraged to use CPAP with O2 during NOC [night]."</p> <p>A Physician Orders sheet, dated 9/6/14, hand</p>	F 328	<p><u>Monitoring</u></p> <p>Starting the week of 11/10/14, an audit will be completed by the Director of Nursing or designee weekly x 4 weeks and monthly for 2 months of 5 residents with orders for oxygen or CPAP machine to ensure that physician orders are being followed accurately. Results of the audits will be reported to the Performance Improvement Committee monthly for 3 months for review and remedial intervention. The Director of Nursing is responsible for monitoring and compliance. The Performance Improvement Committee will re-evaluate the need for further monitoring after 3 months.</p> <p><u>Date of Compliance</u></p> <p>11/7/14</p>		

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F 328	Continued From page 55 written by the physician, documented, "Be sure patient uses CPAP." On 9/24/14 at 10:15 AM, the DON was interviewed and stated, "The CPAP came with the patient on admission, 8/21/14, it was in use but we did not get an order in the computer until 9/4 and it was not care planned." On 9/24/14 at 12:30 PM, the Administrator, MCO and DON were made aware of the CPAP concerns. No further information was provided by the facility which resolved the concerns.	F 328			
F 353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.	F 353	<u>F353</u> <u>Specific Residents Identified</u> The 12 residents who attended group will be assessed by the Director of Nursing or designee on or before 11/7/14 for any adverse effect related to staffing concerns. Any findings will be addressed and corrected by the Director of Nursing on or before 11/7/14. The nursing schedule was updated by the Director of Nursing on or before 11/7/14 to include additional nursing assistant coverage during and after dinner starting 11/7/14. A Resident Council meeting will be held by the Administrator or designee on or before 11/7/14 related to the schedule adjustments and call light response times. Any findings will be addressed and changes implemented on or before 11/7/14 by the Director of Nursing or Designee. Resident # 6 has been discharged from the facility.		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 353	<p>Continued From page 56</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, resident group interview, record review and staff interview it was determined the facility did not ensure adequate nursing staff to meet resident needs. This was true for 1 of 13 (#6) sampled residents, and 8 of 12 residents in the resident group. The deficient practice had the potential to cause harm when residents had to wait extended periods of time for staff assistance before, during, and after the evening meal. Findings included:</p> <p>On 9/23/14 at 1:30 PM, 8 of 12 residents in the Resident Group stated the facility did not have enough nursing help. Specifically, the residents stated call lights could take 30 to 60 minutes for staff to respond. The Resident Group stated this was most prevalent in the evening, starting just before dinner, and continuing into the evening until many of the residents had gone to bed. The residents stated once staff had responded to call lights during those times, the wait for actual assistance could be delayed even longer for residents needing 2-person assistance. Investigation of these resident concerns revealed: *Resident #6 fell at 5:20 PM on 8/3/14. The facility's investigation included a CNA's statement that s/he was the only person on the floor at that time. *On 9/24/14 at 11:15 AM, the DNS was asked about staffing during the dinner meal. The DNS stated it would not be unusual to have only 1 CNA working the floor at that time of day, due to the need to provide breaks and ensure staff were in the dining room. The DNS stated, "They have to take their breaks between 2:00 and 5:00 in the afternoon."</p>	F 353	<p><u>Identification of Other Residents</u></p> <p>A review of the call light response times will be completed by the Administrator or designee during and after dinner on or before 11/7/14. Any findings will be addressed and changes implemented on or before 11/7/14 by the Director of Nursing or designee.</p> <p>A Resident Council meeting will be held by the Administrator or designee on or before 11/7/14 related to the schedule adjustments and call light response times. Any findings will be addressed and changes implemented on or before 11/7/14 by the Director of Nursing or designee.</p> <p><u>Systemic Changes</u></p> <p>Facility staff has been educated by the Administrator or designee on or before 11/7/14 regarding answering call lights and new staffing pattern and assignments during and after dinner to meet residents' needs.</p>	

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F 353	Continued From page 57 *Two of 4 evening shift nursing personnel (NP) interviewed confirmed the Resident Group concerns. NP #s 5 and 7 stated it took significantly longer to answer call lights once residents started going to the dining room for dinner because only 1 CNA was assigned to look after all 4 wings of the facility during that time. NP #7 stated the current staffing levels in the evening "didn't seem like enough." NP #s 5 and 7 stated wings with higher acuity residents had even slower call light response times than other wings. *On 9/25/14 at 3:10 PM, the surveyors walked the length of the facility layout. There was a centrally located nurse's station, with 4 resident care wings jutting from it in an "X" pattern. From each resident care wing, the nurse's station could be seen, but not the other care wings. Once on a care wing, only the call lights for that wing could be seen. Each wing was approximately 200 to 250 feet in length. The dining room was located at the end of a hallway, extending from the nurse's station between the 100 and 400 wings. The hallway to the dining room was approximately 125 feet in length. Once in the hallway leading to the dining room, the resident care wings and call lights were no longer visible. Based on the observations of the facility layout, it was not possible to determine how one staff person could attend to all 4 wings at one time. On 9/26/14 at 10:00 AM, the Administrator, DNS, and MCO were informed of these findings. The facility offered no further information.	F 353	<u>Monitoring</u> Starting the week of 11/10/14, a call light response time audit of 5 call lights will be completed during and after the dinner meal by the Director of Nursing or designee weekly x 4 weeks and then monthly x 2 months to ensure that call lights are responded to timely and that residents' needs are met. The results of those audits will be reported to the Performance Improvement Committee for three months for review and remedial intervention. The Administrator is responsible for compliance and monitoring. The Performance Improvement Committee will re-evaluate the need for further monitoring after 3 months. Results of the audits will also be reviewed in resident council meeting monthly x 3 months. <u>Date of Compliance</u> 11/7/14		
F 464 SS=E	483.70(g) REQUIREMENTS FOR DINING & ACTIVITY ROOMS The facility must provide one or more rooms designated for resident dining and activities.	F 464			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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	<p>Continued From page 58</p> <p>These rooms must be well lighted; be well ventilated, with nonsmoking areas identified; be adequately furnished; and have sufficient space to accommodate all activities.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to provide an adequate amount of sitting chairs in the dining and activity rooms. This was true for 1 random resident (#24) and any other resident in the facility who would like to sit in a chair in those rooms. There was a potential for psychosocial harm if residents were not allowed to transfer to a sitting chair and treated in a dignified manner. Findings include:</p> <p>On 9/24/14 from 6:07 to 6:15 PM, the dining room was observed during the evening meal. Resident #25 approached a dining room table in a wheelchair, where a metal folding chair had been placed. The resident appeared agitated and voiced her displeasure to staff regarding the folding chair. CNA #4 and the Administrator looked throughout the dining room and then the Administrator approached a resident's guest and spoke to her, at which point the guest stood up from a sitting chair with arms and accepted a folding chair from the Administrator. The sitting chair was then brought to Resident #25's table, where she was transferred to that chair. There were 6 sitting chairs in the dining room and were all occupied. There were 4 folding chairs and one was occupied by a guest.</p> <p>On 9/24/14 at 6:15 PM, CNA #4 was interviewed.</p>		<p><u>F-464</u></p> <p><u>Specific Residents Identified</u></p> <p>Resident #24 has been assessed by the Director of Nursing on 10/21/14 and no adverse effects were noted from the incident. Seating in the dining room and activity room was reviewed by the Administrator or designee on or before 11/7/14 and there are adequate chairs in the dining room so that resident #24 has a chair in the dining room that she is transferred to for each meal.</p> <p><u>Identification of Other Residents</u></p> <p>An audit of chairs in the dining room and activity room was completed on 10/20/14 by the Administrator and there are adequate chairs in the dining room and activity room so residents who desire to sit in a chair are able to do so. A Resident Council meeting was held by the Administrator or designee on or before 11/7/14 related to adequate seating in the dining room and activity room. Any findings will be corrected by the administrator or designee on or before 11/7/14. A purchase order for 20 additional chairs</p>	

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F 464	<p>Continued From page 59</p> <p>She said the folding chairs were for guests and when they needed more sitting chairs for residents, staff would take them from the conference room. She said, however, since the surveyors occupied the conference room, the staff did not want to take chairs from there and possibly disturb the surveyors.</p> <p>On 9/24/14 at 6:25 PM, the conference room chairs were observed. There were 9 sitting chairs, but only one chair was the same color and design as the ones found in the dining room.</p> <p>On 9/24/14 at 6:28 PM, the Administrator was interviewed regarding the chair issue. When asked what staff would do if all or most of the residents wanted to use a sitting chair in the dining room, she said, "We would not have enough chairs for everyone."</p> <p>On 9/25/14 at 8:31 AM, the MCO provided a list of 12 residents in the facility who could self transfer and would potentially want to use a sitting chair in the dining and activity rooms.</p> <p>On 9/25/14 at 8:40 AM, the Activity room was observed. There were 4 sitting chairs with arms and 3 folding chairs in the room.</p> <p>On 9/25/14 at 3:45 PM, the Administrator, DON, and MCO were informed of the chair issues. No further information was provided.</p>	F 464	<p>was approved by the administrator and regional staff on 10/20/14.</p> <p><u>Systematic Changes</u></p> <p>Facility staff have been educated by the Administrator or designee on or before 11/7/14 regarding provision of chairs to residents in the dining room and activity room. Staff educated to notify the administrator for correction if there are not an adequate number of chairs in the dining room or activity room.</p> <p><u>Monitoring</u></p> <p>Starting the week of 11/10/14, an audit will be completed by the Administrator or designee weekly x 4 weeks and then monthly x 2 months to ensure that there is adequate seating in the dining room and activity room for residents. A report will be submitted to the Performance Improvement Committee monthly for 3 months for review and remedial intervention. The PI committee will re-evaluate the need for further audits after 3 months. The Administrator is responsible for monitoring and compliance. Results of the audits will be reviewed at the</p>	
F 514 SS=D	<p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional</p>	F 514		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 514	<p>Continued From page 60</p> <p>standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility failed to ensure residents' records were complete and accurate. This was true for 2 of 13 (#s 5 and 6) sampled residents. The deficient practice had the potential for harm when information on a resident's clinical condition was not accurately documented, and it was not clear when or by whom care plan updates had been made. Findings included:</p> <p>1. Resident #6 was admitted to the facility on 7/16/14 with multiple diagnoses which included a history of COPD and CAD.</p> <p>The resident's TAR, beginning on 7/16/14, instructed fluid intake and output was to be documented to the nearest milliliter each shift.</p> <p>Thirty of the thirty-five documentation opportunities for this information did not include a measurement amount for how much the resident voided. On 7/28/14, the resident was admitted to the acute care hospital for an exacerbation of COPD and fluid overload.</p>	F 514	<p>Resident Council meeting monthly x 3 months.</p> <p><u>Date of Compliance</u></p> <p>11/7/14</p> <p><u>F-514</u></p> <p><u>Specific Residents Identified</u></p> <p>Residents #5 and #6 have been discharged from the facility.</p> <p><u>Identification of Other Residents</u></p> <p>A review has been completed by the Director of Nursing or designee on or before 11/7/14 of the treatment records (TAR) to ensure that fluid intake and output is measured and documented per physician order. Any findings will be corrected by the Director of Nursing or designee on or before 11/7/14. A review of resident care plans was completed by the Director of Nursing or designee on or before 11/7/14 for any interventions that did not include initials or dates. Any identified issues will have corrections made to the care plans including initials and dates by the Director of Nursing or designee on or before 11/7/14 as needed.</p>		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135104	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/26/2014
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NAME OF PROVIDER OR SUPPLIER TWIN FALLS CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 674 EASTLAND DRIVE TWIN FALLS, ID 83301
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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 514	<p>Continued From page 61</p> <p>On 9/24/14 at 10:05 AM, the DNS was asked about the information on the resident's TAR. The DNS was unable to discern, from the documentation present, how much the resident had voided for the shifts in question.</p> <p>On 9/26/14 at 10:00 AM the Administrator, DNS, and MCO were informed of these findings. The facility offered no further information.</p> <p>2. Resident #5 was admitted on 7/26/14 with diagnoses of rehabilitation, hemiplegia affecting unspecified side due to cerebrovascular disease and aphasia due to cerebrovascular disease.</p> <p>The resident's Self Care Deficit care plan, dated 7/28/14, documented handwritten interventions of: "Inc[ontinent] B&B [Bowel and Bladder]-staff to offer toilet q [every] 2 [hours] & PRN." and "Hard of hearing -wears hearing aides bilaterally. Staff to adjust the tone & volume of their voices -staff to help [with] use of hearing aides." Note: Neither intervention had an implementation start date or was signed.</p> <p>On 9/24/14 at 4:40 PM, the MDS Coordinator was interviewed and was asked if the interventions were dated or signed and she stated, "I didn't, I should have."</p> <p>On 9/25/14 at 3:45 PM, the Administrator, DON, and MCO were informed of the documentation issues. No further information was provided by the facility.</p>	F 514	<p><u>Systematic Changes</u></p> <p>Licensed nurses and the Interdisciplinary Team have been educated by the Director of Nursing or designee on or before 11/7/14 regarding accurate documentation of resident clinical conditions and how to update care plans to include the date and initial with additional interventions and accurate intake and output documentation.</p> <p><u>Monitoring</u></p> <p>Starting the week of 11/10/14, audits of 5 records will be completed weekly x 4 weeks and then monthly for 2 months by the Director of Nursing or designee to ensure that the clinical condition of the resident is accurately reflected in the care plan. Starting the week of 11/10/14, audits of 5 records will be completed by the Director of Nursing or designee weekly x 4 weeks and then monthly for 2 months to ensure that documentation in the treatment record of intake and output is accurate. Results of audits will be reported to the Performance Improvement Committee for 3 months for review and remedial intervention. The Director of Nursing is responsible for monitoring and compliance. The Performance Improvement Committee</p>	
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will re-evaluate the need for further monitoring after 3 months.

Date of Compliance

11/7/14

Bureau of Facility Standards

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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 surveyors conducting the survey were: Brad Perry, BSW, LSW, Team Coordinator Nina Sanderson, BSW, LSW Judy Atkinson, RN Rebecca Thomas, RN Susan Gollobit, RN The following deficiencies were cited during the State licensure and complaint survey of your facility.	C 000		
C 111	02.100,02,f Provide for Sufficient/Qualified Staff f. The administrator shall be responsible for providing sufficient and qualified staff to carry out all of the basic services offered by the facility, i.e., food services, housekeeping, maintenance, nursing, laundry, etc. This REQUIREMENT is not met as evidenced by: Please see F 353 as it pertains to facility staffing.	C 111	C111 See POC for F353 <u>Date of Compliance</u> 11/7/14	
C 119	02.100,03,c,iii Informed of Medical Condition by Physician iii. Is fully informed, by a physician, of his medical condition unless medically contraindicated (as documented, by a physician, in his medical record), and is afforded the opportunity to participate in the	C 119	C119 See POC for F154 <u>Date of Compliance</u> 11/7/14	

RECEIVED
OCT 23 2014
FACILITY STANDARDS

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

Joni Bentley

TITLE
Administrator

(X6) DATE
10/21/14

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001800	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/26/2014
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C 119	Continued From page 1 planning of his medical treatment and to refuse to participate in experimental research; This Rule is not met as evidenced by: Please refer to F154 as related to Black Box Warning.	C 119		
C 124	02.100,03,c,viii Confidentiality of Records viii. Is assured confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in case of his transfer to another health care facility, or as required by law or third-party payment contract; This Rule is not met as evidenced by: Please refer to F164 as related to exposed records.	C 124	<u>C124</u> See POC for F164 <u>Date of Compliance</u> 11/7/14	
C 155	02.100,08 NOTIFICATION OF CHGE PTNT/RSDNT STATUS 08. Notification of Change in Patient/Resident Status. There shall be written policies and procedures relating to notification of next of kin, or sponsor, in the event of a significant change in a patient's/resident's status. This Rule is not met as evidenced by: Please see F 157 as it pertains to family notification.	C 155	<u>C155</u> See POC for F157 <u>Date of Compliance</u> 11/7/14	
C 173	02.100,12,d Immediate Notification of Physician of Injury d. The physician shall be	C 173		

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C 173	Continued From page 2 immediately notified regarding any patient/resident injury or accident when there are significant changes requiring intervention or assessment. This Rule is not met as evidenced by: Please see F 157 as it pertains to physician notification.	C 173	<u>C173</u> See POC for F157 <u>Date of Compliance</u> 11/7/14	
C 361	02.108,07 HOUSEKEEPING SERVICES AND EQUIPMENT 07. Housekeeping Services and Equipment. Sufficient housekeeping and maintenance personnel and equipment shall be provided to maintain the interior and exterior of the facility in a safe, clean, orderly and attractive manner. This Rule is not met as evidenced by: Refer to F252 regarding shower room issues.	C 361	<u>C361</u> See POC for F252 <u>Date of Compliance</u> 11/7/14	
C 393	02.120,04,b Staff Calling System at Each Bed/Room b. A staff calling system shall be installed at each patient/resident bed and in each patient/resident toilet, bath and shower room. The staff call in the toilet, bath or shower room shall be an emergency call. All calls shall register at the staff station and shall actuate a visible signal in the corridor at the patient's/resident's door. The activating mechanism within the patient's/resident's sleeping room shall be so located as to be readily accessible to the patient/resident at all times.	C 393	<u>C393</u> See POC for F246 <u>Date of Compliance</u> 11/7/14	

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C 393	Continued From page 3 This Rule is not met as evidenced by: Please refer to F246 as related to call lights.	C 393	<u>C411</u>	
C 411	02.120,05,k All Resident Rooms Numbered 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 4 rooms in the facility were labeled. This had the potential to affect residents or visitors. Findings include: On 9/22/14 from 3:35 to 3:40 PM, the following rooms did not have any identification on them: *The Medication room; *A dirty utility room in the 300 hallway; *A Copy room; and, *The Rehabilitation Manager's office. On 9/22/14 at 3:40 PM, the Administrator was shown these rooms and was asked why there were no signs to identify the rooms and she stated, "I don't know." She said she would have signs placed on the doors.	C 411	<u>Specific and Other Residents Identified</u> Identification signs have been put in place for the Medication Room, the dirty utility room on the 300 hallway, the copy room and the Rehabilitation Manager's office by the Maintenance Director on or before 11/7/14. An audit of the facility was completed by the Administrator or designee on or before 11/7/14 to ensure that identification signs are in place on each room in the facility. Any findings were corrected. <u>Systemic Changes</u> The Maintenance Director has been educated by the Administrator on or before 11/7/14 regarding the requirement that rooms in the facility have identifying signs.	
C 666	02.150,02,c Quarterly Committee Meetings c. Meet as a group no less often than quarterly with documented minutes of meetings maintained showing members present, business addressed and signed and dated by the chairperson. This Rule is not met as evidenced by: Based on review of the Infection Control Meeting Minutes and staff interview, it was determined the facility failed to ensure a representative from each department was included and signed in at the	C 666	<u>Monitoring</u> Starting the week of 11/10/14, an audit will be completed by the administrator or designee weekly x 4 weeks and then monthly x 2 months to ensure that rooms in the facility have identifying signs. Results of the audits	

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C 666	Continued From page 4 Infection Control Meetings. This failure has the potential to affect all residents, staff, and visitors to the facility through the potential spread of infectious agents. Findings included: The facility's Infection Control Protocol was reviewed on 9/25/14 at 1:35 PM. with the DON, who provided the sign-in sheet from the Quarterly Infection Control Meeting. Upon review of the sign-in sheets, it was determined that Dietary, Housekeeping and Maintenance departments were not represented. On 9/25/14 at 3:45 PM, the Administrator and DON were made aware of the above concern. No further information was provided by the facility.	C 666	will be reported to the Performance Improvement Committee monthly for 3 months for review and remedial intervention. The Administrator is responsible for monitoring and compliance. The PI committee will re-evaluate the need for ongoing audits after 3 months. <u>Date of Compliance</u> 11/7/14 <u>C666</u> <u>Specific and Other Residents Identified</u>	
C 745	02.200,01,c Develop/Maintain Goals/Objectives c. Developing and/or maintaining goals and objectives of nursing service, standards of nursing practice, and nursing policy and procedures manuals; This Rule is not met as evidenced by: Please refer to F281 as related to pre signing medication records.	C 745	A meeting of the Infection Control Committee was held on or before 11/7/14 and included representatives from each department including Dietary, Housekeeping and Maintenance.	
C 778	02.200,03,a PATIENT/RESIDENT CARE 03. Patient/Resident Care. a. A patient/resident plan of care shall be developed in writing upon admission of the patient/resident, which shall be: This Rule is not met as evidenced by: Please see F 279 as it pertains to care plan	C 778	<u>Systemic Changes</u> The facility managers were educated by the Administrator on or before 11/7/14 regarding the requirements for the Infection Control Committee.	

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C 778	Continued From page 5 development.	C 778	<u>Monitoring</u>	
C 779	02.200,03,a,i Developed from Nursing Assessment i. Developed from a nursing assessment of the patient's/resident's needs, strengths and weaknesses; This Rule is not met as evidenced by: Refer to F272 regarding the lack of cognitive loss care plan.	C 779	Starting the week of 11/7/14, a monthly audit will be completed by the administrator x 3 months to ensure that the requirements for an Infection Control Meeting are met. Results of the audits will be reported to the Performance Improvement Committee monthly for 3 months for review and remedial intervention. The Administrator is responsible for monitoring and compliance. The PI Committee will re-evaluate the need for ongoing audits after 3 months.	
C 781	02.200,03,a,iii Written Plan, Goals, and Actions iii. Written to include care to be given, goals to be accomplished, actions necessary to attain the goals and which service is responsible for each element of care; This Rule is not met as evidenced by: Please refer to F-328 as it relates to CPAP.	C 781	<u>Date of Compliance</u>	
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 F280 regarding care plans not revised.	C 782	11/7/14 <u>C745</u> See POC for F281 <u>Date of Compliance</u>	
C 784	02.200,03,b Resident Needs Identified b. Patient/resident needs shall be recognized by nursing staff and nursing services shall be provided to assure that each patient/resident receives care necessary to meet his	C 784	11/7/14 <u>C778</u> See POC for F279 <u>Date of Compliance</u>	

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C 784	Continued From page 6 total needs. Care shall include, but is not limited to: This Rule is not met as evidenced by: Please see F 309 as it pertains to delay in treatment, and pain monitoring.	C 784	<u>C779</u> See POC for F272 <u>Date of Compliance</u>	
C 787	02.200,03,b,iii Fluid/Nutritional Intake iii. Adequate fluid and nutritional intake, including provisions for self-help eating devices as needed; This Rule is not met as evidenced by: Please refer to F-325 as it relates to weight loss.	C 787	11/7/14 <u>C781</u> See POC for F328	
C 788	02.200,03,b,iv Medications, Diet, Treatments as Ordered iv. Delivery of medications, diet and treatments as ordered by the attending physician, dentist or nurse practitioner; This Rule is not met as evidenced by: Refer to F328 regarding oxygen therapy.	C 788	<u>Date of Compliance</u> 11/7/14 <u>C782</u> See POC for F280	
C 790	02.200,03,b,vi Protection from Injury/Accidents vi. Protection from accident or injury; This Rule is not met as evidenced by: Please see F 323 as it pertains to falls, restraint safety assessments, and equipment storage.	C 790	<u>Date of Compliance</u> 11/7/14 <u>C784</u> See POC for F309	
C 791	02.200,03,b,vii ORAL HYGIENE vii. Oral hygiene; This Rule is not met as evidenced by: Please refer to F310 as related to oral hygiene.	C 791	<u>Date of Compliance</u> 11/7/14	

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C 795	Continued From page 7	C 795	<u>C787</u>	
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 F315 regarding an incomplete bladder assessment.	C 795	See POC for F325 <u>Date of Compliance</u> 11/7/14 <u>C788</u> See POC for F328	
C 881	02.203,02 INDIVIDUAL MEDICAL RECORD 02. Individual Medical Record. An individual medical record shall be maintained for each admission with all entries kept current, dated and signed. All records shall be either typewritten or recorded legibly in ink, and shall contain the following: This Rule is not met as evidenced by: Please see F 514 as it pertains to medical records.	C 881	<u>Date of Compliance</u> 11/7/14 <u>C790</u> See POC for F323 <u>Date of Compliance</u> 11/7/14 <u>C791</u> See POC for F310 <u>Date of Compliance</u> 11/7/14	

C795

See POC for F315

Date of Compliance

11/7/14

C881

See POC for F514

Date of Compliance

11/7/14



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

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

November 26, 2014

Lori Bentzler, Administrator
Twin Falls Center
674 Eastland Drive
Twin Falls, ID 83301-6846

Provider #: 135104

Dear Ms. Bentzler:

On **September 26, 2014**, a Complaint Investigation survey was conducted at Twin Falls Center. Judy Atkinson, RN, Susan Gollobit, RN, Becky Thomas, RN, Nina Sanderson, LSW, and Bradley Perry, LSW, conducted the complaint investigation.

A total of 48 hours were required to complete this and another complaint investigation.

During the investigation, the Director of Nursing (DON), Dietary Manager (DM), CNAs and shower aides were interviewed. Additionally, residents were interviewed individually and as a group.

The following documents were reviewed:

The identified resident's closed record;
The identified resident's hospital discharge and transfer summary;
The Menu for the month of November 2013;
Resident Council meeting minutes from April through September 2014;
Facility Grievance/Concern Forms from September 2013 through September 2014;
Facility Policy and Procedure for Activities of Daily Living;
Facility Policy and Procedure for Interim/Stat/Emergency Supply of Medications; and,
Residents and their families were interviewed.

The complaint allegations, findings and conclusions are as follows:

FILE COPY

Complaint #ID00006327

ALLEGATION #1:

The complainant stated the first morning, after the resident's admission to the facility, the resident was told there was no milk for his cereal and staff offered him root beer instead. The second morning, the resident was served sauerkraut and sausage with toast for breakfast. Additionally, the resident was not offered alternatives and was not given enough food. When he asked for more food, the resident was told he had to wait until everyone else was served.

FINDINGS:

The identified resident was admitted on November 27, 2013 and discharged on December 2, 2013. The DM was interviewed and stated the residents are offered milk at every meal. She stated they receive a shipment of milk two times per week. When asked if residents are ever served root beer for breakfast, the DM stated the residents have a soda fountain available in the dining room and can have it anytime, if they desire. When asked if the facility served sauerkraut and sausage with toast for breakfast, the DM stated she was unaware that anyone was served sauerkraut and sausage with toast for a breakfast meal. She stated the facility had an omelette bar, cold cereal and toast available as an alternative to the breakfast meal. The DM offered a copy of the menus for November 2013, which did not include sauerkraut and sausage. At the resident group council meeting, residents did not have any complaints with breakfast meals or receiving milk, and stated they had plenty of food. Several residents were interviewed privately who did not have any complaints with receiving enough to eat or with getting food alternatives.

CONCLUSION:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The complainant stated there was a shortage of staff throughout his stay. The resident ate his meals in his room and there wasn't any staff in the halls to answer his call light during meals.

FINDINGS:

Multiple observations were made during the investigation and recertification survey in regard to call lights. On September 22, 2014, during the initial tour of the facility, three residents were observed not to have their call lights within reach. The facility was cited at F 246 for not providing residents with access to their call lights.

CONCLUSION:

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

ALLEGATION #3:

The complainant stated the resident had an order for Lomotil for diarrhea and the facility was unable to get it because it was a narcotic, that he either did not get the needed Lomotil or she had to bring from home.

FINDINGS #3:

The identified resident's medical record documented an order for Lomotil with a start date of November 27, 2013 and the resident received Lomotil on November 29th. The resident's bowel movement schedule was reviewed and documented the resident had one small loose stool on the 27th and one small loose stool on the 28th. No documentation was found in the medical record which indicated the resident was having diarrhea. The DON was interviewed and stated the facility has a local pharmacy it uses if a medication is needed which it does not have on hand; it takes from 1-2 hours after a medication is ordered for the facility to receive it from the pharmacy. This allegation was unsubstantiated.

FINDINGS: Unsubstantiated. Allegation did not occur.

ALLEGATION #4

The complainant was told he could only have a shower and linen change one time per week and would need to wait until Thursday, December 5, 2013. The resident wanted a shower before Thursday, and his wife offered to help him, but the facility would not let her assist him.

FINDINGS #4

A CNA and 2 shower aides who provided showers/baths for residents were interviewed and asked if they had problems with not enough time or staff to provide showers, baths and change linens. They stated they gave showers 2 times per week, that linens are changed on shower days, and on a as needed basis. When asked how long after admission a resident is given a shower, a CNA stated within 24 hours or as soon as possible. When asked what the facility does when a resident refuses a shower, the CNA stated they send another CNA to shower the resident as sometimes the resident doesn't care for a certain CNA.

The identified resident's medical record documented he received a bed bath during his four day stay at the facility. Other resident charts were audited for showers/baths. The facility provided

Lori Bentzler, Administrator
November 26, 2014
Page 4 of 4

them as care planned. Resident interviews during the survey process indicated residents were happy with their shower schedule and that linens were changed on shower days, when soiled, or as needed. This allegation was not substantiated due to lack of evidence.

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.I.D.P. or David Scott, R.N., Supervisors, Long Term Care at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

A handwritten signature in black ink that reads "Lorene Kayser". The signature is written in a cursive, slightly slanted style.

LORENE KAYSER, LSW, QIDP, Supervisor
Long Term Care

LK/lj



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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November 20, 2014

Lori A. Bentzler, Administrator
Twin Falls Center
674 Eastland Drive
Twin Falls, ID 83301-6846

FILE COPY

Provider #: 135104

Dear Ms. Bentzler:

On **September 26, 2014**, a Complaint Investigation survey was conducted at Twin Falls Center. Bradley Perry, L.S.W., Nina Sanderson, L.S.W., Judy Atkinson, R.N., Becky Thomas, R.N. and Susan Gollobit, R.N. conducted the complaint investigation. A total of 20 hours was required to investigate this complaint and three other complaints.

The complaint allegations, findings and conclusions are as follows:

Complaint #6414

ALLEGATION #1:

The complainant stated while in the facility on March 15, 2014, the complainant observed a resident on the floor and staff walked by without assisting the resident. The complainant stated it took about ten minutes for staff to assist the resident.

FINDINGS #1:

During the investigation, the facility's resident identification list was reviewed and multiple observations were completed.

During the investigation, staff were observed throughout the facility providing cares for the

Lori A. Bentzler, Administrator
November 20, 2014
Page 2 of 3

residents; no problems were identified.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

On March 15, 2014, while the complainant was visiting, in the facility, the complainant observed the resident in room #207 scooting himself on the floor. No resident's name was provided.

FINDINGS #2:

During the investigation, observations were made and the facility's resident identification list was reviewed.

The resident who occupied room #207 was a new admittance and was not in the building in March 2014.

There were no residents observed to be on the floor.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

On March 15, 2014, while the complainant was visiting, in the building, the licensed staff did not assist the CNAs answer call lights.

FINDINGS #3:

During the investigation, the response times to call lights were monitored.

During the observations, response times to answer call lights were acceptable, and licensed staff as well as CNAs answered the call lights. During the initial tour of the facility, on September 22, 2014, a surveyor observed three residents whose call lights were not accessible to them.

The facility was cited at F246 for call lights not being accessible to the residents.

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

Lori A. Bentzler, Administrator
November 20, 2014
Page 3 of 3

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.I.D.P. or David Scott, R.N., Supervisors, Long Term Care at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

A handwritten signature in black ink that reads "Lorene Kayser". The signature is written in a cursive, slightly slanted style.

LORENE KAYSER, L.S.W., Q.I.P.D., Supervisor
Long Term Care

LKK/dmj



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

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3232 Elder Street
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November 26, 2014

Lori Bentzler, Administrator
Twin Falls Center
674 Eastland Drive
Twin Falls, ID 83301-6846

Provider #: 135104

Dear Ms. Bentzler:

On **September 26, 2014**, a Complaint Investigation survey was conducted at Twin Falls Center. Judy Atkinson, RN, Susan Gollobit, RN, Becky Thomas, RN, Bradley Perry, LSW, conducted the complaint investigation.

This and a second complaint investigation were conducted in conjunction with a recertification survey.

During the investigation the Director of Nursing (DON), Dietary Manager (DM), Registered Dietitian (RD), Certified Nurse Aides (CNAs), and residents and their families were interviewed. Observations of resident care was conducted. Facility grievance/concern forms and the records of 25 residents, including that of the identified resident, were reviewed.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00006481

ALLEGATION #1:

The complainant stated the resident was admitted on May 5, 2014, and was promised a shower which she did not receive until May 9, 2014.

FINDINGS:

The identified resident's record documented she had been provided a shower on May 7, 2014 and a shower or bed bath was provided four more times between May 9 and May 24, 2014. The resident had also refused a shower two times.

Other resident charts were audited for showers/baths. The facility provided them as care planned.

A CNA who provided showers/baths for the residents was asked if she had problems with not enough time or staff to provide the shower or baths. No problems were identified by other residents in the facility or by the survey team.

CONCLUSION:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The complainant stated the resident was left alone in her wheelchair in the dining room or in the hallway and was unable to move herself.

FINDINGS:

Throughout the survey, observations of residents in the dining room, hallways and throughout the facility were conducted.

Facility staff provided residents with assistance to move about the facility as they needed. Residents were not left for long periods in the dining room or hallways.

CONCLUSION:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The complainant stated the staff were not respectful of the resident's clothes. The clothes were dumped and left on the floor.

FINDINGS:

Lori Bentzler, Administrator
November 26, 2014
Page 3 of 5

During the investigation, multiple resident rooms were observed for clothes on the floor. There was no evidence of clothes or inappropriately placed personal belongings on the floors. During a resident interview, the resident stated the staff were respectful of the resident's belongings and did not put clothes on the floor.

CONCLUSION:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

The complainant stated the resident had a fall from her wheelchair on May 6, 2014, and the staff may have had a role in the fall.

FINDINGS:

According to the identified resident's record, on May 8, 2014, the Physical Therapist (PT) was assisting the resident back into bed. When the PT turned to put the resident's walker away, the resident slid out of her wheelchair as she tried to transfer herself. The resident was not injured in the incident. On May 9, 2014, the facility put the resident on half hour checks. On May 9, 2014, the Occupational Therapist (OT) observed the resident trying to get out of bed by herself to go to the bathroom. The OT notified the nursing staff through a communication form, but nursing made no changes in a toileting program to assist the resident regularly to the bathroom.

The facility was cited at F 323 for not implementing interventions to protect the resident from another fall. The facility was cited at F 279 for not updating the resident's care plan with interventions for falls and toileting the resident.

FINDINGS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #5:

The complainant stated the staff did not answer the resident's call light.

FINDINGS:

During multiple observations throughout the investigation and recertification survey, resident

Lori Bentzler, Administrator
November 26, 2014
Page 4 of 5

call lights were observed.

On September 22, 2014, during the initial tour of the facility, three residents were observed not to have their call lights within reach.

The facility was cited at F 246 for not providing residents with access to their call lights.

FINDINGS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #6:

The complainant stated that when trying to call the resident, the facility's phone goes to voice mail.

FINDINGS:

During the investigation, observations were made of the facility's main telephone ringing and being answered.

During the observations, the facility had a receptionist who answered the phone. Staff were also observed to answer the phone. The phone did not ring for long periods of time.

It could not be determined that facility did not answer the phone timely.

CONCLUSION:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #7:

The complainant stated the identified resident's husband had talked to facility staff/administration; however, there was no improvement in care.

FINDINGS:

The resident's admission orders, dated May 6, 2014, documented the physician wanted the resident to receive a supplement per the RD recommendation. On May 8, 2014, the RD completed an assessment on the resident and recommended the house supplement be provided to the resident. On May 9, 2014 the resident's husband filed a concern that the resident did not

Lori Bentzler, Administrator
November 26, 2014
Page 5 of 5

received her health shake/supplement. The record documented the resident did not start receiving the supplement until May 13, 2014. The DON, DM and RD verified the resident did not receive the supplement in a timely manner as ordered and recommended.

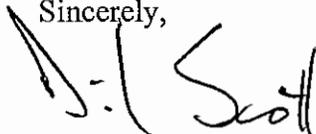
The facility failed to provide the house supplement as requested by the physician on May 6, 2014, and recommended by the RD on May 8, 2014 until May 13, 2014. The facility was cited at F 325 for not providing the nutritional supplement required by the resident in a timely manner.

FINDINGS:

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

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

Sincerely,

A handwritten signature in black ink that reads "David Scott". The signature is written in a cursive style with a large, stylized "D" and "S".

DAVID, SCOTT, RN, Supervisor
Long Term Care

DS/lj



IDAHO DEPARTMENT OF
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Twin Falls Center
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Twin Falls, ID 83301-6846

Provider #: 135104

Dear Ms. Bentzler:

On **September 26, 2014**, a Complaint Investigation survey was conducted at Twin Falls Center. Judy Atkinson, RN, Susan Gollobit, RN, Becky Thomas, RN, Nina Sanderson, LSW, and Bradley Perry, LSW, conducted the complaint investigation.

A total of 48 hours were required to complete this and another complaint investigation.

During the investigation, the Director of Nursing (DON) and Registered Dietician (RD) were interviewed. Additionally, residents were interviewed individually and as a group.

The following documents were reviewed:

The identified resident's closed record;
The identified resident's hospital ER record;
Resident Council Meeting minutes from April through September 2014; and,
Grievances from September 2013 through September 2014

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00006681

ALLEGATION #1:

The complainant stated the resident fell, cut his knee in a Twin Falls resident assisted living facility and was admitted to the skilled nursing facility for IV antibiotic treatment. The IV antibiotic was not administered but the knee eventually healed.

FINDINGS #1:

The identified resident was admitted to the facility on August 21, 2014 from an assisted living residence due to recurrent falls and poorly healing laceration of his left knee. The resident's closed record included the physician's admitting history and physical which documented the resident was not on an IV antibiotic but was ordered Bactrim DS 2 tablets by mouth twice a day for 10 days. Additionally, the resident's recapitulation orders for September 2014 documented the aforementioned order for Bactrim DS with a start date of August 21, 2014 for the diagnosis of Cellulitis, Knee. Therefore, this allegation of the complaint was unsubstantiated.

CONCLUSION:

Unsubstantiated. Allegation did not occur.

ALLEGATION #2:

The complainant stated on September 17, 2014 the resident was sent to a local hospital ER following an appointment with a physician due to shaking and hallucinating, and was admitted due to dehydration and malnutrition after just one month in the facility. The complainant stated the resident was reaching out for things that weren't there, shaking, and couldn't speak well. The resident was discharged the same day to the facility.

FINDINGS:

The resident's medical record documented the resident was seen by a psychiatrist on September 17, 2014 and sent the resident to the emergency room for further evaluation. The complainant stated the resident was admitted to the emergency room due to dehydration and malnutrition, however, the emergency room medical record documented the resident was evaluated for confusion and discharged back to the facility. The resident's physician progress note, dated September 17, 2014, documented the emergency room obtained a chest x-ray which was negative and lab results which were normal. Blood cultures and urine cultures were obtained and IV fluids were administered. The resident's primary care physician visited the resident at the facility that evening and documented, "The patient has delusions and hallucinations and at times is more clear. I think he maybe having some component of dementia related to his Down Syndrome. No clear metabolic etiology has been discerned." The resident was discharged back to the assisted living facility on September 19, 2014 at the POA's request.

The identified resident's medical record documented the resident experienced a 10 pound weight loss before the facility identified the resident was losing weight. This allegation was substantiated and the facility was cited at F 325 for nutrition services.

Lori Bentzler, Administrator
November 26, 2014
Page 3 of 3

CONCLUSION:

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

ALLEGATION #3:

The complainant stated the resident was not provided his CPAP (Continuous Positive Airway Pressure) the first night at the skilled nursing facility.

FINDINGS:

The identified resident was admitted on August 21, 2014 with multiple diagnoses which included obstructive sleep apnea. A physician progress note, dated August 20, 2014, was accepted as the admitting history and physical, and documented the resident was to continue with his CPAP device at the skilled nursing facility. The resident's Inventory of Personal Effects documented the resident arrived at the facility with his CPAP device. No documentation was found the resident used his CPAP on admission. The first documentation an order for CPAP was obtained and the resident used his CPAP was on September 4, 2014 This allegation was substantiated and the facility was cited at F 328 for respiratory care and F 279 for care plan interventions.

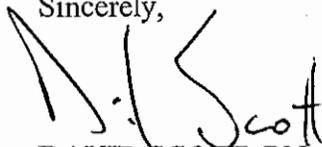
CONCLUSION:

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

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

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

Sincerely,

A handwritten signature in black ink that reads "David Scott". The signature is stylized and cursive.

DAVID SCOTT, RN, Supervisor
Long Term Care

DS/lj