



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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BUREAU OF FACILITY STANDARDS
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October 16, 2013

Stephen Farnsworth, Administrator
Pocatello Care & Rehabilitation Center
527 Memorial Drive
Pocatello, ID 83201-4063

Provider #: 135011

RE: October 8, 2013, Second Follow-Up Revisit of the April 26, 2013, Recertification,
Complaint Investigation and State Licensure Survey

Dear Mr. Farnsworth:

On **October 8, 2013**, we conducted an on-site follow-up revisit to verify that your facility had achieved and maintained compliance. We had presumed, based on your allegation of compliance, that your facility was in substantial compliance as of **August 12, 2013**. However, based on our on-site follow-up revisit conducted **October 8, 2013**, we found that your facility is not in substantial compliance with the following participation requirements:

- F164 -- S/S: E -- 42 CFR §483.10(e), 483.75(l)(4) -- Personal Privacy/Confidentiality of Records**
- F314 -- S/S: D -- 42 CFR §483.25(c) -- Treatment/Services to Prevent/Heal Pressure Sores**
- F425 -- S/S: D -- 42 CFR §483.60(a),(b) -- Pharmaceutical Service - Accurate Procedures, Registered Pharmacist**
- F514 -- S/S: D -- 42 CFR §483.75(l)(1) -- Resident Records-Complete/Accurate/Accessible**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing

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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. **Please provide ONLY ONE completion date for each federal and state tag in column X5 (Complete Date), to signify when you allege that each tag will be back in compliance.** After each deficiency has been answered and dated, the administrator should sign both Statement of Deficiencies and Plan of Correction, Form CMS-2567 and State Form, in the spaces provided and return the originals to this office.

Your copy of the Post-Certification Revisit Report, Form CMS-2567B, listing deficiencies that have been corrected is enclosed.

Your Plan of Correction (PoC) for the deficiencies must be submitted to this office **as soon as possible.**

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

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

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- Include dates when corrective action will be completed in column 5.

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

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

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

As noted in our previous letters to you, following the **Recertification, Complaint Investigation and State Licensure** survey of **April 26, 2013**, and the **first follow up revisit** of **July 11, 2013**, we have already made the recommendation to the Centers for Medicare and Medicaid Services (CMS) for Denial of Payment for New Admissions and termination of the provider agreement on **October 26, 2013**, if substantial compliance is not achieved by that time.

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

STATE ACTIONS effective with the date of this letter (**October 16, 2013**): NONE

If you believe the deficiencies have been corrected, you may contact Loretta Todd, R.N. or Lorene Kayser, L.S.W., Q.M.R.P., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0036; phone number: (208) 334-6626; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You may also contest scope and severity assessments for deficiencies, which resulted in a finding of SQC or immediate jeopardy. 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/NursingFa>

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[ilities/tabid/434/Default.aspx](#)

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

- BFS Letters (06/30/11)

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

This request must be received by **October 31, 2013**. If your request for informal dispute resolution is received after **October 31, 2013**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the on-site follow-up revisit. If you have any questions or concerns, please contact this office at (208) 334-6626.

Sincerely,



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

LT/dmj
Enclosures

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135011	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 10/08/2013
NAME OF PROVIDER OR SUPPLIER POCATELLO CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 527 MEMORIAL DRIVE POCATELLO, ID 83201		
(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 an on-site follow up to a recertification survey.</p> <p>The surveyors conducting the survey were: Brad Perry, BSW, LSW, Team Coordinator Arnold Rosling RN, BSN, QMRP</p> <p>The survey team entered the facility on Monday, October 7, 2013, and exited the facility on Tuesday, October 8, 2013.</p> <p>Survey Definitions: cm = Centimeters DON = Director of Nursing LN = Licensed Nurse MAR = Medication Administration Record MDS = Minimum Data Set assessment MG = Milligrams SDTI = Suspected deep tissue injury</p> <p>F 164 483.10(e), 483.75(l)(4) PERSONAL SS=E PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone 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>	{F 000}		10/22/13	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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 164	<p>Continued From page 1</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 staff interview it was determined the facility failed to ensure PHI (personal health information) about residents' pressure sores was protected. This was true for 2 of 2 (#s 23 & 24) sampled residents with pressure sores and 6 (#s 4, 20, 27, 28, 29 & 30) additional residents. Not securing residents' PHI potentially could harm a resident if the information was stolen or lost and used by unauthorized sources. Findings include:</p> <p>The following information was obtained during an interview with the medical record employee (MR 1) and ADON on 10/8/13 at 12:10 p.m.:</p> <p>The ADON stated the facility skin team monitored residents almost weekly for skin problems. The monitoring was kept on a spreadsheet and was stored on a thumb drive the ADON maintained. This spreadsheet was then printed and provided to the surveyors. The spreadsheet was titled "Weekly skin monitoring" with the subtitle "Pressure Ulcer monitoring." Upon review of the thumb drive spreadsheet the first entry found was</p>	F 164		

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F 164	<p>Continued From page 2</p> <p>for the week of 8/13/13. The subsequent assessment dates were: 8/19/13, 8/23/13, 8/26/13, 9/3/13, 9/16/13, 9/23/13 and 9/29/13. Information found on each page of the thumb drive spreadsheet were: resident's name, birth date, room number, date of onset, location of skin sores, assessment date, onset date, current stage descriptive information and a section for additional information.</p> <p>MR 1 was asked if she was responsible for implementing HIPPA requirements in the facility and she indicated she was. MR 1 was asked if she was aware of the staff using a thumb drive to store resident health information. She indicated she was not aware. The ADON was asked if the information on the thumb drive was encrypted to prevent someone from retrieving the information who was not authorized to see it. He was not aware of what encryption was and indicated IT was responsible for encryption. He further indicated the thumb drive was secured in his office but indicated there was no safe or locked drawer to ensure it was secure.</p> <p>Residents #4, 20, 23, 24, 27, 28, 29 and 30 all had personal health information recorded on the spreadsheet on the thumbdrive. Specifics included:</p> <p>1. Resident #23 was admitted to the facility, on 7/18/13 with diagnoses of pneumonia, chronic airway obstruction, and muscle weakness.</p> <p>The most recent admission MDS, dated 7/25/13, documented the resident had one unstageable pressure sore.</p> <p>Resident #23's name, room number, birth date,</p>	F 164			

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F 164	<p>Continued From page 3</p> <p>location and description of the two pressure sores the resident had, were found on the thumb drive spreadsheet. One example of the information on the thumb drive was the 9/29/13 page entry which documented: Date of onset: 7/29/13, Acquired in house: no, R[oo]M: [room number], Resident: [Name], Location: R heel, Assess[ment] date: 9/29/13, Onset Stage: SDTI, Current Stage: SDTI, H[eight]: 0.2, W[idth]: 0.4, D[epth]: UDT [sic] [unable to determine], RTT [Response to treatment]: I[mproved], Note: black dry, and DOB: [date of birth].</p> <p>2. Resident #24 was admitted to the facility, on 6/9/13 and readmitted on 8/23/13, with diagnoses of bipolar disorder, pressure ulcer lower back, anxiety state and infection with microorganism that is resistant.</p> <p>The most recent quarterly MDS, dated 10/3/13, documented the resident had a stage IV pressure sore present on admission.</p> <p>Resident #24's name, room number, birth date, location and description of the stage IV pressure sore the resident had was found on the thumb drive. One example of the information on the thumb drive was the 9/29/13 page entry which documented: Date of onset: 6/28/13, Acquired in house: no, RM: [room number], Resident: [Name], Location: Coccyx, Assess date: 9/29/13, Onset Stage: IV, Current Stage: III, H: 4h/3, W: 2.0, D: 3.0, RTT: W = [deteriorated], Note: 75%, and DOB: date of birth.</p> <p>3. Resident #4 was admitted to the facility on 1/12/12 and readmitted on 2/9/12.</p> <p>Resident #4's name, room number and descriptions of five pressure sores were found on</p>	F 164			

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F 164	<p>Continued From page 4</p> <p>the spreadsheet on the thumb drive. One example of the information on the spreadsheet was the 8/19/13 page entry which documented: Date of onset: 7/2/13, Acquired in house: yes, Rm: [number], Resident: [Name], Location: L medial cunieforn, Assess Date: 8/20/13, Onset stage: SDTI, Current Stage: SG (stage) III, H: 0.3, W: 1.8, D: UTD (unable to determine), RTT: I, Note: 15%-75% slough.</p> <p>4. Resident #20 was admitted to the facility on 3/19/13.</p> <p>Resident #20's name, room number and descriptions of six pressure sores were found on the spreadsheet on the thumb drive. One example of the information on the spreadsheet was the 8/13/13 page entry which documented: Date of onset: left blank, Acquired in house: [Name], Rm: [number], Resident: [Name], Location: L heel, Assess Date: 8/7/13, Onset stage: SDTI, Current Stage: SG II, H: 1.2, W: 2, D: <0.1, RTT: I, Note: 100% granulation.</p> <p>5. Resident #27 was admitted to the facility on 1/3/13 and readmitted on 5/2/13.</p> <p>Resident #27's name, room number and descriptions of two pressure sores were found on the spreadsheet on the thumb drive. One example of the information on the spreadsheet was the 8/19/13 page entry which documented: Date of onset: 8/11/13, Acquired in house: yes, Rm: [number], Resident: [Name], Location: Coccyx, Assess Date: 8/20/13, Onset stage: II, Current Stage: II, H: 2, W: 1.5, D: 0.0, RTT: N[ew], Note: slough.</p> <p>6. Resident #28 was admitted to the facility on</p>	F 164		

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F 164	<p>Continued From page 5 9/27/13.</p> <p>Resident #28's name, birthdate, room number and descriptions of two pressure sores were found on the spreadsheet on the thumb drive. One example of the information on the spreadsheet was the 9/29/13 page entry which documented: Date of onset: 9/25/13, Acquired in house: no, Rm: [number], Resident: [Name], Location: R[ight] Heel, Assess Date: 9/29/13, Onset stage: Unstageable, Current Stage: Unstageable, H: 2.0, W: 2.0, D: UTD, RTT: s[ame], Note: purple bruise.</p> <p>7. Resident #29 was admitted to the facility on 9/20/13.</p> <p>Resident #29's name, birthdate, room number and descriptions of two pressure sores were found on the spreadsheet on the thumb drive. One example of the information on the spreadsheet was the 9/29/13 page entry which documented: Date of onset: 9/20/13, Acquired in house: no, Rm: [number], Resident: [Name], Location: R Heel, Assess Date: 9/29/13, Onset stage: II, Current Stage: II, H: 2.0, W: 2.0, D: 0.5, RTT: I, Note: Blister.</p> <p>8. Resident #30 was admitted to the facility on 9/24/13 and readmitted on 10/5/13.</p> <p>Resident #30's name, birthdate, room number and description of one pressure sore was found on the spreadsheet on the thumb drive. One example of the information on the spreadsheet was the 9/29/13 page entry which documented: Date of onset: 9/24/13, Acquired in house: no,</p>	F 164		

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F 164	Continued From page 6 Rm: [number], Resident: [Name], Location: Sacrum, Assess Date: 9/29/13, Onset stage: Unstageable, Current Stage: Unstageable, H: blank, W: blank, D: blank, RTT: blank, Note: Eschar/slough. The Administrator and DON were informed on 10/8/13 at 12:30 p.m. No further information was provided.	F 164			
{F 314} SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on staff interview, observation and record review, the facility failed to document information on a resident's right heel pressure sore. This was true for 1 of 4 (#23) sampled residents. This practice created a potential for harm if the facility does not document or track pressure sore status to determine if treatment is effective. Further, the facility failed to develop a care plan addressing the right heel pressure sore. Findings include: Resident #23 was admitted to the facility, on 7/18/13 with diagnoses of pneumonia, chronic airway obstruction, and muscle weakness.	{F 314}		10/22/13	

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{F.314}	Continued From page 7 The most recent admission MDS, dated 7/25/13, documented the resident: * had short and long term memory problems, * required extensive assist with bed mobility, transfers, dressing, toileting and personal hygiene, * had one unstageable pressure sore. The interpretive guidance at F 314 specifies the facility should document on each pressure sore at a minimum the following information: "ULCER CHARACTERISTICS It is important that the facility have a system in place to assure that the protocols for daily monitoring and for periodic documentation of measurements, terminology, frequency of assessment, and documentation are implemented consistently throughout the facility. When a pressure ulcer is present, daily monitoring, (with accompanying documentation, when a complication or change is identified), should include: ·An evaluation of the ulcer, if no dressing is present; ·An evaluation of the status of the dressing, if present (whether it is intact and whether drainage, if present, is or is not leaking); ·The status of the area surrounding the ulcer (that can be observed without removing the dressing); ·The presence of possible complications, such as signs of increasing area of ulceration or soft tissue infection (for example: increased redness or swelling around the wound or increased drainage from the wound); and ·Whether pain, if present, is being adequately controlled. With each dressing change or at least weekly	{F 314}			

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{F 314}	<p>Continued From page 8 (and more often when indicated by wound complications or changes in wound characteristics), an evaluation of the pressure ulcer wound should be documented. At a minimum, documentation should include the date observed and:</p> <ul style="list-style-type: none"> · Location and staging; · Size (perpendicular measurements of the greatest extent of length and width of the ulceration), depth; and the presence, location and extent of any undermining or tunneling/sinus tract; · Exudate, if present: type (such as purulent/serous), color, odor and approximate amount; · Pain, if present: nature and frequency (e.g., whether episodic or continuous); · Wound bed: Color and type of tissue/character including evidence of healing (e.g., granulation tissue), or necrosis (slough or eschar); and · Description of wound edges and surrounding tissue (e.g., rolled edges, redness, hardness/induration, maceration) as appropriate." <p>The resident's comprehensive care plan dated 7/23/13 documented a Focus of: "Has actual impairment to skin integrity related to history of pressure ulcer to coccyx and sacrum and current SDTI [suspected deep tissue injury] site to left heel related to limited mobility." There was no care plan for the sore on the right heel SDTI in the medical record.</p> <p>The resident's medical record was reviewed on 10/9/13. It contained information indicating that the resident had two pressure sores. There was one on the right heel and one on the left heel. The record lacked clear information about the right heel pressure sore.</p> 	{F 314}			

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

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NAME OF PROVIDER OR SUPPLIER POCATELLO CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 527 MEMORIAL DRIVE POCATELLO, ID 83201		
(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 314}	Continued From page 9 The electronic medical record had three different types of documentation on pressure sores. The "LN -Admission Assessment Comprehensive" had a section on skin integrity. There was an assessment titled "LN-Skin Assessment Evaluation - PRN Weekly," one titled, "LN - Skin Pressure Ulcer Weekly," and one titled, "LN-Interdisciplinary Team Skin Review - Weekly Update." There was extensive documentation on the pressure sore on the left heel but only rare documentation of the right heel. The only documentation found for in the record for the the right heel was as follows: The "LN-Admission Assessment Comprehensive" form, dated 7/18/13, did not have any information about the pressure sores on the heels. The form only addressed there were "2 pressure areas on [the] buttocks" and "cracks on bilateral heels [sic]." The "LN - Skin Pressure Ulcer Weekly" first documentation was 7/18/13 but lacked anything about the right heel. Subsequent documentation was completed weekly about the left heel. There was nothing about the right heel. This form had a place for the information that is recommended by the interpretive guidance for F 314. This form was completed by the ADON who was the wound nurse. The "LN -Skin Assessment / Evaluation - PRN Weekly" only documented the "Site, Type, Length, Width, Depth, and Stage" information with a box for additional comments. The forms documented: The 8/14/13 documentation for the right heel was: "Site Right heel, Type Pressure, Length 1.5,	{F 314}			

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{F 314}	<p>Continued From page 10</p> <p>Width 1.5, Depth blank, Stage Suspected Deep Tissue Injury [SDTI]." The additional comments were: "Bilateral heels to have skin prep daily and monitored for change. Both heel beds are black at current time. Wound beds are hard and deep tissue is unable to stage at current time." The 8/17/13 documentation was: "1) Bilateral heels are black and hard to touch." The 8/31/13 documentation was: "1) Bilateral heels are black and hard."</p> <p>The "LN -interdisciplinary Team Skin Review - Weekly Update" documented only one note about the right heel; the rest were about the left heel only. This documentation was: On 8/16/13 at Section II "Wound Management/Pressure ulcer Review" was documented, "SDTI's to bilat[eral]heels..." At Section V "Response to Treatment Plan was documented, "Bilateral heels to have skin prep daily and monitored for change. wound to left heel measures in cm 2.5 x 2.5 x 0. wound to right heel measures in cm 1.5 x 1.5 x 0. Both wound beds are black at current time. Wound beds are hard and deep tissue is unable to stage at current time...."</p> <p>There was no other documentation describing the right heel wound in the record.</p> <p>On 10/8/13 at 9:10 a.m. Resident #23's heels were observed. The resident had a sore on the right heel which was about 1 cm in diameter covered with an eschar and was unstageable.</p> <p>The Administrator, DON and assistant director of nursing (ADON) were interviewed on 10/8/13 at 10:30 a.m. They indicated that they were monitoring the sore on the right heel but</p>	{F 314}			

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{F 314}	Continued From page 11 acknowledged the medical record was lacking descriptive documentation of that wound. They indicated descriptive information outlined in the interpretive guidance was on a spreadsheet that was located on a thumb drive, and was not associated with the electronic medical record, nor was there a copy in the paper medical record for review. The information on the thumb drive was not available in the record, either electronically or hard copy, for surveyors or practitioners to review. They indicated the ADON updated the information during the skin meetings. A paper copy of the spreadsheet from the thumb drive was provided to the surveyors. The thumb drive, according to the ADON interview on 10/8/13 at 12:10 p.m., was kept in the ADON's office and the information was updated when the skin team met each week. See F 164 also for more information on the thumb drive. The facility failed to monitor the pressure sore on the right heel, failed to document if the treatment ordered was effective for the resident and failed to have a care plan for the right heel pressure sore.	{F 314}			
{F 514} SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient	{F 514}		10/22/13	

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{F 514}	<p>Continued From page 12</p> <p>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 the facility had failed ensure the residents electronic medical record contained descriptive information about the pressure sore on the right heel. This was true for 1 of 4 (# 23) sampled residents. There is a potential for harm if the facility does not document or track a pressures sore to see if treatment is working. Findings include:</p> <p>Resident #23 was admitted to the facility on 7/18/13 with diagnoses of pneumonia, chronic airway obstruction, and muscle weakness.</p> <p>The most recent admission MDS, dated 7/25/13, documented the resident: * had short and long term memory problems, * required extensive assist with bed mobility, transfers, dressing, toileting and personal hygiene, * had an unstageable pressure sore.</p> <p>The interpretive guidance at F 314 documents the facility should document on each pressure sore at a minimum the following information:</p> <p>"ULCER CHARACTERISTICS It is important that the facility have a system in place to assure that the protocols for daily monitoring and for periodic documentation of measurements, terminology, frequency of</p>	{F 514}		

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{F 514}	<p>Continued From page 13</p> <p>assessment, and documentation are implemented consistently throughout the facility. When a pressure ulcer is present, daily monitoring, (with accompanying documentation, when a complication or change is identified), should include:</p> <ul style="list-style-type: none"> ·An evaluation of the ulcer, if no dressing is present; ·An evaluation of the status of the dressing, if present (whether it is intact and whether drainage, if present, is or is not leaking); ·The status of the area surrounding the ulcer (that can be observed without removing the dressing); ·The presence of possible complications, such as signs of increasing area of ulceration or soft tissue infection (for example: increased redness or swelling around the wound or increased drainage from the wound); and ·Whether pain, if present, is being adequately controlled. <p>With each dressing change or at least weekly (and more often when indicated by wound complications or changes in wound characteristics), an evaluation of the pressure ulcer wound should be documented. At a minimum, documentation should include the date observed and:</p> <ul style="list-style-type: none"> ·Location and staging; ·Size (perpendicular measurements of the greatest extent of length and width of the ulceration), depth; and the presence, location and extent of any undermining or tunneling/sinus tract; ·Exudate, if present: type (such as purulent/serous), color, odor and approximate amount; ·Pain, if present: nature and frequency (e.g., whether episodic or continuous); 	{F 514}			

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{F 514}	<p>Continued From page 14</p> <p>-Wound bed: Color and type of tissue/character including evidence of healing (e.g., granulation tissue), or necrosis (slough or eschar); and</p> <p>-Description of wound edges and surrounding tissue (e.g., rolled edges, redness, hardness/induration, maceration) as appropriate."</p> <p>The resident's medical record was reviewed on 10/9/13. It contained information indicating that the resident had two pressure sores. There was one on the right heel and one on the left heel. The record lacked clear information about the right heel pressure sore.</p> <p>The electronic medical record had three different types of documentation on pressure sores. The "LN -Admission Assessment Comprehensive" had a section on skin integrity. There was an assessment titled "LN-Skin Assessment Evaluation - PRN Weekly," one titled, "LN - Skin Pressure Ulcer Weekly," and one titled, "LN-Interdisciplinary Team Skin Review - Weekly Update." There was extensive documentation on the pressure sore on the left heel but only rare documentation of the right heel. The only documentation found for in the record for the the right heel was as follows:</p> <p>The "LN-Admission Assessment Comprehensive" form, dated 7/18/13, did not have any information about the pressure sores on the heels. The form only addressed there were "2 pressure areas on [the] buttocks" and "cracks on bilateral heels [sic]."</p> <p>The "LN - Skin Pressure Ulcer Weekly" first documentation was 7/18/13 but lacked anything about the right heel. Subsequent documentation was completed weekly about the left heel. There</p>	{F 514}			

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{F 514}	<p>Continued From page 15</p> <p>was nothing about the right heel. This form had a place for the information that is recommended by the interpretive guidance for F314. This form was completed by the ADON who was the wound nurse.</p> <p>The "LN -Skin Assessment / Evaluation - PRN Weekly" only documented the "Site, Type, Length, Width, Depth, and Stage" information with a box for additional comments. The forms documented:</p> <p>The 8/14/13 documentation for the right heel was: "Site Right heel, Type Pressure, Length 1.5, Width 1.5, Depth blank, Stage Suspected Deep Tissue Injury [SDTI]." The additional comments were: "Bilateral heels to have skin prep daily and monitored for change. Both heel beds are black at current time. Wound beds are hard and deep tissue is unable to stage at current time."</p> <p>The 8/17/13 documentation was: "1) Bilateral heels are black and hard to touch."</p> <p>The 8/31/13 documentation was: "1) Bilateral heels are black and hard."</p> <p>The "LN -interdisciplinary Team Skin Review - Weekly Update" documented only one note about the right heel; the rest were about the left heel only. This documentation was: On 8/16/13 at Section II "Wound Management/Pressure ulcer Review" was documented, "SDTI's to bilat[eral]heels..." At Section V "Response to Treatment Plan was documented, "Bilateral heels to have skin prep daily and monitored for change. wound to left heel measures in cm 2.5 x 2.5 x 0. wound to right heel measures in cm 1.5 x 1.5 x 0. Both wound beds are black at current time. Wound beds are hard and deep tissue is unable to stage at current time...."</p>	{F 514}			

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{F 514}	<p>Continued From page 16</p> <p>There was no other documentation describing the right heel wound in the record.</p> <p>On 10/8/13 at 9:10 a.m. Resident #23's heels were observed. The resident had a sore on the right heel which was about 1 cm in diameter covered with an eschar and was unstageable.</p> <p>The Administrator, DON and assistant director of nursing (ADON) were interviewed on 10/8/13 at 10:30 a.m. They indicated that they were monitoring the sore on the right heel but acknowledged the medical record was lacking descriptive documentation of that wound. They indicated descriptive information outlined in the interpretive guidance was on a spreadsheet that was located on a thumb drive, and was not associated with the electronic medical record, nor was there a copy in the paper medical record for review. The information on the thumb drive was not available in the record, either electronically or hard copy, for surveyors or practitioners to review. They indicated the ADON updated the information during the skin meetings. A paper copy of the spreadsheet from the thumb drive was provided to the surveyors after the interview.</p> <p>The thumb drive, according to the ADON interview on 10/8/13 at 12:10 p.m., was in the ADON's office and the information was updated when the skin team met each week. See F 164 also for more information on the thumb drive.</p> <p>The facility failed to document if the treatment ordered was effective for the resident, and failed to have a medical record that accurately documented the status and progress of the pressure sore.</p>	{F 514}			

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October 18, 2013

Federal Citations

F 164 E

1. Resident numbers 6, 20, 23, 24, 27, 28, 29 and 30 were identified. The information was transferred to the facility's encrypted network and the thumb drive was destroyed on 10-8-13.
2. All residents receiving wound care have potential to be affected.
3. The skin committee was in-serviced on 10-9-13 to only document personal health information on the encrypted network files. The only members of the wound care team that have access to the encrypted files are the Director of Nursing, the Assistant Director of Nursing and the lead wound nurse.
4. The administrator or his medical records designee will audit the security of the wound reports to ensure they are on the secure network weekly x4 weeks, then every 2 weeks x4 weeks, then monthly x3 months. Audits will be reviewed by the QAA committee and recommendations will be made until it has been determined by the committee that the system is effective. The audits began on 10-9-13.
5. Date of compliance is 10/22/2013.

October 18, 2013

F 314 D

1. Resident #23 was identified. The wound report containing information pertaining to the patient's wounds (location & staging, size, depth & presence, location and extent of any undermining tunneling/sinus tract, exudate, pain, wound bed color, and type of tissue, character including evidence of healing and description of wound edges & surrounding tissue) was uploaded into the patient's encrypted electronic medical record on 10-8-13.
2. All residents with wounds have the potential to be affected by this practice. Current residents with wounds were reviewed to ensure that all components of wound documentation were present in the patient's medical record.
3. Skin committee (Director of Nursing or ADON) will audit the documentation on the skin/wound assessments weekly to ensure all components are addressed (location & staging, size, depth & presence, location and extent of any undermining tunneling/sinus tract, exudate, pain, wound bed color, and type of tissue, character including evidence of healing and description of wound edges & surrounding tissue) for each wound.
4. The DON or ADON will review the documentation on the skin/ wound assessments for completeness of all required elements. Audits will be reviewed by the QAA committee and recommendations will be made until it has been determined by the committee that the system is effective. Audits to begin 10-21-13.
5. Date of compliance is 10/22/2013.

October 18, 2013

F 514 D

1. Resident #23 was identified. The wound report containing information pertaining to the patient's wounds (location & staging, size, depth & presence, location and extent of any undermining tunneling/sinus tract, exudate, pain, wound bed color, and type of tissue, character including evidence of healing and description of wound edges & surrounding tissue) was uploaded into the patient's encrypted electronic medical record on 10-8-13.
2. All residents with wounds have the potential to be affected by this practice.
3. Skin committee (Director of Nursing or ADON) will audit the documentation on the skin/wound assessments weekly to ensure all components are addressed (location & staging, size, depth & presence, location and extent of any undermining tunneling/sinus tract, exudate, pain, wound bed color, and type of tissue, character including evidence of healing and description of wound edges & surrounding tissue) for each wound.
4. The DON or ADON will review the documentation on the skin/ wound assessments for completeness of all required elements. Audits will be reviewed by the QAA committee and recommendations will be made until it has been determined by the committee that the system is effective. Audits to begin 10-21-13.
5. Date of compliance is 10/22/2013.

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001020	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 10/08/2013
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NAME OF PROVIDER OR SUPPLIER POCATELLO CARE & REHABILITATION CENTI	STREET ADDRESS, CITY, STATE, ZIP CODE 527 MEMORIAL DRIVE POCATELLO, ID 83201
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{C 000}	<p>16.03.02 INITIAL COMMENTS</p> <p>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.</p> <p>The following deficiencies were cited during an on-site follow up to a recertification survey.</p> <p>The surveyors conducting the survey were: Brad Perry, BSW, LSW, Team Coordinator Arnold Rosling RN, BSN, QMRP</p> <p>The survey team entered the facility on Monday, October 7, 2013, and exited the facility on Tuesday, October 8, 2013.</p>	{C 000}		
C 124	<p>02.100,03,c,viii Confidentiality of Records</p> <p>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: Refer to F164 as it relates to medical record privacy.</p>	C 124		10/22/13
{C 789}	<p>02.200,03,b,v Prevention of Decubitus</p> <p>v. Prevention of decubitus ulcers or deformities or treatment thereof, if needed, including, but not limited to, changing position every two (2) hours when confined to bed or wheelchair and opportunity for</p>	{C 789}		10/22/13

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001020	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 10/08/2013
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{C 789}	Continued From page 1 exercise to promote circulation; This Rule is not met as evidenced by: Refer to F 314 as it relates to pressure sores.	{C 789}		
C 879	02.203 PATIENT/RESIDENT RECORDS 203. PATIENT/RESIDENT RECORDS. The facility maintains medical records for all patients/residents in accordance with accepted professional standards and practices. This Rule is not met as evidenced by: Refer to F 514 as it relates to medical records.	C 879		10/22/13

October 18, 2013

State Citations

C 124

1. Resident numbers 6, 20, 23, 24, 27, 28, 29 and 30 were identified. The information was transferred to the facility's encrypted network and the thumb drive was destroyed
2. All residents receiving wound care have potential to be affected.
3. The skin committee was in-serviced on 10-9-13 to only document personal health information on the encrypted network files. The only members of the wound care team that have access to the encrypted files are the Director of Nursing, the Assistant Director of Nursing and the lead wound nurse.
4. The administrator or his medical records designee will audit the security of the wound reports to ensure they are on the secure network weekly x4 weeks, then every 2 weeks x4 weeks, then monthly x3 months. The audits began on 10-9-13. Audits will be reviewed by the QAA committee and recommendations will be made until it has been determined by the committee that the system is effective.
5. Date of compliance is 10/22/2013.

October 18, 2013

C 789

1. Resident #23 was identified. The wound report containing information pertaining to the patient's wounds (location & staging, size, depth & presence, location and extent of any undermining tunneling/sinus tract, exudate, pain, wound bed color, and type of tissue, character including evidence of healing and description of wound edges & surrounding tissue) was uploaded into the patient's encrypted electronic medical record on 10-8-13.
2. All residents with wounds have the potential to be affected by this practice. Current residents with wounds were reviewed to ensure that all components of wound documentation were present in the patient's medical record.
3. Skin committee (Director of Nursing or ADON) will audit the documentation on the skin/wound assessments weekly to ensure all components are addressed (location & staging, size, depth & presence, location and extent of any undermining tunneling/sinus tract, exudate, pain, wound bed color, and type of tissue, character including evidence of healing and description of wound edges & surrounding tissue) for each wound.
4. The DON or ADON will review the documentation on the skin/ wound assessments for completeness of all required elements. Audits to begin 10-21-13. Audits will be reviewed by the QAA committee and recommendations will be made until it has been determined by the committee that the system is effective.
5. Date of compliance is 10/22/2013.

October 18, 2013

C 879

1. Resident #23 was identified. The wound report containing information pertaining to the patient's wounds (location & staging, size, depth & presence, location and extent of any undermining tunneling/sinus tract, exudate, pain, wound bed color, and type of tissue, character including evidence of healing and description of wound edges & surrounding tissue) was uploaded into the patient's encrypted electronic medical record on 10-8-13.
2. All residents with wounds have the potential to be affected by this practice.
3. Skin committee (Director of Nursing or ADON) will audit the documentation on the skin/wound assessments weekly to ensure all components are addressed (location & staging, size, depth & presence, location and extent of any undermining tunneling/sinus tract, exudate, pain, wound bed color, and type of tissue, character including evidence of healing and description of wound edges & surrounding tissue) for each wound.
4. The DON or ADON will review the documentation on the skin/ wound assessments for completeness of all required elements. Audits to begin 10-21-13. Audits will be reviewed by the QAA committee and recommendations will be made until it has been determined by the committee that the system is effective.
5. Date of compliance is 10/22/2013.

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

PRINTED: 11/19/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135011	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/08/2013
NAME OF PROVIDER OR SUPPLIER POCATELLO CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 527 MEMORIAL DRIVE POCATELLO, ID 83201	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following deficiencies were cited during a complaint investigation survey. The surveyors conducting the survey were: Brad Perry, BSW, LSW, Team Coordinator Arnold Rosling RN, BSN, QMRP The survey team entered the facility on Monday, October 7, 2013, and exited the facility on Tuesday, October 8, 2013. Survey Definitions: DON = Director of Nursing LN = Licensed Nurse MAR = Medication Administration Record MDS = Minimum Data Set assessment MG = Milligrams	F 000		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy	F 425		10/22/13

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

TITLE

(X6) DATE

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.

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

PRINTED: 11/19/2013
FORM APPROVED
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135011	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/08/2013
NAME OF PROVIDER OR SUPPLIER POCATELLO CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 527 MEMORIAL DRIVE POCATELLO, ID 83201		
(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 425	<p>Continued From page 1 services in the facility.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility did not ensure medications ordered by the physician were available. This was true for 1 of 1 resident (#26) sampled for medication availability. The deficient practice had the potential to cause more than minimal harm if a resident experienced increased nausea, hypertension, and edema, when not receiving her prescribed medications. Findings included:</p> <p>Resident #26 was admitted to the facility on 7/12/13 with multiple diagnoses including pneumonia, muscle weakness, history of hypertension, and history of edema.</p> <p>The resident's physician's orders on the July 2013 MAR documented: -7/12/13, Zofran ODT (Ondansetron) by mouth, 4 MG TID [three times a day] everyday for Nausea. -7/12/13, Lasix (Furosemide) by mouth, 40 MG *QD [every day] for Hypertension and Edema.</p> <p>According to the resident's MAR for July 2013, on three occasions the prescribed dose of Zofran and on one occasion the prescribed dose of Lasix were not available to administer to the resident. These were: 7/13/13 and 7/14/13 at 8:00 AM and 7/13/13 at 2:00 PM, the LN documented, "Zofran ODT-not available." 7/13/13 at 8:00 AM, the LN documented,</p>	F 425			

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

PRINTED: 11/19/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135011	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C. 10/08/2013
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NAME OF PROVIDER OR SUPPLIER POCATELLO CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 527 MEMORIAL DRIVE POCATELLO, ID 83201
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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 425	<p>Continued From page 2</p> <p>"Lasix-not available."</p> <p>Note: The resident's Progress Notes did not contain an explanation as to why the resident did not receive the prescribed medications or any adverse side affects the resident experienced.</p> <p>On 10/8/13 at 10:20 AM, the DON was interviewed regarding the missed medication administrations. When shown the MAR, she stated the resident, "did not get it." When asked why the medications were missed, she said the resident may have been out of the facility with family and would check on that.</p> <p>On 10/8/13 at 11:23 AM, the DON said she could not verify if the resident was out of the facility or not, the surveyor showed the MAR to the DON where other medications were given at the times in question and asked why weren't the medications in question given. The DON said she would check. The surveyor then asked if the medications were not readily available, did the LN check the emergency medication supply. The DON said she would check with pharmacy to see if those medications were stocked at the time.</p> <p>On 10/8/13 at 12:30 PM, the Administrator, DON, ADON, Administrator in Training, and Clinical Resources were informed of the issue. No further information was provided.</p>	F 425		
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October 18, 2013

F 425 D

1. Resident #26 was identified. In-serviced licensed nurses on 10-9-13 on the protocol for obtaining medications for residents from the pyxis (emergency medication dispensing unit) and pharmacy. Education also included notifying the physician if the medication is not available for alternate order until the medication can be obtained. All LN pyxis access was confirmed and education was also provided on the use of the pyxis. Resident #26 was discharged on 7-16-13.
2. All residents have the potential to be affected. Reviewed current medication administration record to ensure all medications are available for all residents.
3. Licensed nurses will compare new admission orders to the medications delivered by the pharmacy at the time of delivery to ensure all medications ordered were received or are available in the pyxis. The physician will be notified of any medications that are unavailable so an alternative medication can be given until the original medication is available.
4. The LNs will complete the "unavailable medication log" on a shift by shift basis and turn it in to the DON on a daily basis. The DON or ADON will audit this log 3x weekly to ensure the medication or an alternate was obtained for the resident. Audits will be done 3X weekly for 4 weeks, then weekly x4 weeks, then every 2 weeks x4 weeks, then monthly x3 months. Audits will begin on 10-21-13. Audits will be reviewed by the QAA committee and recommendations will be made until it has been determined by the committee that the system is effective.
5. Date of compliance 10/22/2013

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001020	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/08/2013
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NAME OF PROVIDER OR SUPPLIER POCATELLO CARE & REHABILITATION CENTE	STREET ADDRESS, CITY, STATE, ZIP CODE 527 MEMORIAL DRIVE POCATELLO, ID 83201
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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) COMPLETE DATE
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C 000	<p>16.03.02 INITIAL COMMENTS</p> <p>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.</p> <p>The following deficiencies were cited during a complaint investigation survey.</p> <p>The surveyors conducting the survey were: Brad Perry, BSW, LSW, Team Coordinator Arnold Rosling RN, BSN, QMRP</p> <p>The survey team entered the facility on Monday, October 7, 2013, and exited the facility on Tuesday, October 8, 2013.</p>	C 000		
C 867	<p>02.201.07,a EMERGENCY MEDICATION SUPPLY</p> <p>07. Emergency Medication Supply.</p> <p>a. Certain emergency medications shall be available within the facility for occasional use where the pharmacy source is not immediately available.</p> <p>This Rule is not met as evidenced by: Refer to F425 regarding medication not received.</p>	C 867		10/22/13

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X8) DATE
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October 18, 2013

C 867

1. Resident #26 was identified. In-serviced licensed nurses on 10-9-13 on the protocol for obtaining medications for residents from the pyxis (emergency medication dispensing unit) and pharmacy. Education also included notifying the physician if the medication is not available for alternate order until the medication can be obtained. All LN pyxis access was confirmed and education was also provided on the use of the pyxis. Resident #26 was discharged on 7-16-13.
2. All residents have the potential to be affected. Reviewed current medication administration record to ensure all medications are available for all residents.
3. Licensed nurses will compare new admission orders to the medications delivered by the pharmacy at the time of delivery to ensure all medications ordered were received or are available in the pyxis. The physician will be notified of any medications that are unavailable so an alternative medication can be given until the original medication is available.
4. The LNs will complete the "unavailable medication log" on a shift by shift basis and turn it in to the DON on a daily basis. The DON or ADON will audit this log 3x weekly to ensure the medication or an alternate was obtained for the resident. Audits will be done 3X weekly for 4 weeks, then weekly x4 weeks, then every 2 weeks x4 weeks, then monthly x3 months. Audits will begin on 10-21-13. Audits will be reviewed by the QAA committee and recommendations will be made until it has been determined by the committee that the system is effective.
5. Date of compliance is 10/22/2013



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
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December 6, 2013

Stephen Farnsworth, Administrator
Pocatello Care & Rehabilitation Center
527 Memorial Drive
Pocatello, ID 83201-4063

Provider #: 135011

Dear Mr. Farnsworth:

On **October 8, 2013**, a Complaint Investigation survey was conducted at Pocatello Care & Rehabilitation Center. Bradley Perry, L.S.W. and Arnold Rosling, R.N., Q.M.R.P. conducted the complaint investigation. The complaint was investigated in conjunction with a follow up revisit survey.

The following documents were reviewed:

- The Medication Administration Records of the identified resident and three other residents;
- The entire medical record of the identified resident;
- The facility's grievance logs from July 2013 through October 2013;
- Resident Council meeting minutes from July 2013 through October 2013; and
- Nurse Staffing records from July 11, 2013 through July 15, 2013.

Response times to call lights were observed during the survey. Staff hand washing was observed during the survey.

Interviews were conducted with two residents, the facility's Administrator, Director of Nursing (DoN), Assistant Director of Nursing and Medical Records staff.

The complaint allegations, findings and conclusions are as follows:

Stephen Farnsworth, Administrator
December 6, 2013
Page 2 of 5

Complaint #ID00006116

ALLEGATION #1:

The complainant stated that the identified resident was admitted to the facility on July 12, 2013, and discharged on July 16, 2013, and did not receive dosages of Zofran or Lasix as ordered.

FINDINGS:

The identified resident's Medication Administration Record revealed that the facility failed to give three doses of Zofran and one dose of Lasix.

The complaint was substantiated and the facility was cited at F425 for failure to administer the medications as ordered.

CONCLUSIONS:

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

ALLEGATION #2:

The complainant stated that the identified resident's lungs were not listened to by staff, and the resident's lungs were filling up with fluid.

FINDINGS:

The identified resident no longer resided in the facility. The resident's closed record was reviewed. The closed record provided evidence that the resident received daily respiratory checks by a licensed nurse and the documented results were shown as normal.

Based on records reviewed, it was determined the facility was in compliance with Federal guidelines.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The complainant stated the identified resident was given Intravenous (IV) medications by a Licensed Practical Nurse (LPN) and not a Registered Nurse (RN).

Stephen Farnsworth, Administrator
December 6, 2013
Page 3 of 5

FINDINGS:

The resident's closed record was reviewed. The closed record documented that the resident's only IV medications were antibiotics, which can be administered by an LPN.

The DoN was interviewed about which IV medications were given to the identified resident, and the DoN said only antibiotics were given via the IV, and the resident did not receive any narcotics.

Based on records reviewed and staff interview, it was determined that the facility was in compliance with Federal certification and state licensure guidelines.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

The complainant stated staff failed to wash their hands.

FINDINGS:

Various staff throughout the survey was observed for proper hand washing techniques.

Although the incident may have occurred as described, based on observations the allegation could not be verified, and the facility was in compliance with Federal guidelines.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #5:

The complainant stated the identified resident did not receive lunch.

FINDINGS:

The identified resident's daily meal monitors documented the resident received lunch each day while in the facility.

The DoN was interviewed regarding meal monitoring documentation who said the documentation shows the resident received lunch while in the facility.

Stephen Farnsworth, Administrator
December 6, 2013
Page 4 of 5

Based on records reviewed and interviews, it was determined the facility was in compliance with Federal guidelines.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #6:

The complainant stated call lights were not answered in a timely manner.

FINDINGS:

Observations of call lights were conducted throughout the survey and were answered in a timely manner. The September and October 2013 Resident Council minutes documented that call lights were being answered in a timely manner. Two residents in the facility were interviewed regarding call light response time and were found to be acceptable.

Although the incident may have occurred as described, based on observations, records reviewed and residents' interviews the allegation could not be verified.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #7:

The complainant stated the facility was understaffed during the weekend.

FINDINGS:

Staffing records from the weekend in question were reviewed, and the staffing numbers were in compliance. State licensure rules require 2.4 hours of total nursing staff time per resident per 24-hour day. A review of Resident Council minutes for July 2013 through October 2013 contained no staffing concerns.

Staffing observations were conducted throughout the survey and no concerns were found. Two residents in the facility were interviewed regarding staffing levels and those responses were found to be acceptable.

Although the incident may have occurred as described, based on observations and records reviewed the allegation could not be verified.

Stephen Farnsworth, Administrator
December 6, 2013
Page 5 of 5

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #8:

The complainant stated that the facility told a family member the identified resident's medical record had disappeared.

FINDINGS:

The resident's entire medical record was provided by the Administrator when asked for it. Interviews with Administrator and Medical Records staff were conducted and both stated that the medical record had always been available to the resident or any authorized person to view.

Although the incident may have occurred as described, based on records reviewed and interviews the allegation could not be verified, and the facility was in compliance with Federal guidelines.

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 or concerns regarding our investigation, please contact us 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.M.R.P., Supervisor
Long Term Care

LKK/dmj