



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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

CERTIFIED MAIL: 7012 1010 0002 0836 2090

October 28, 2013

Steve Gannon, Administrator
Safe Haven Care Center of Pocatello
1200 Hospital Way
Pocatello, ID 83201-2708

Provider #: 135071

RE: October 11, 2013, Recertification, Complaint Investigation and State Licensure Survey
Report Cover Letter

Dear Mr. Gannon:

On **October 11, 2013**, a Recertification, Complaint Investigation and State Licensure survey was conducted at Safe Haven Care Center of Pocatello by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be 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**

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in compliance. WAIVER RENEWALS MAY BE REQUESTED ON THE PLAN OF CORRECTION. After each deficiency has been answered and dated, the administrator should sign both Form CMS-2567 and State Form, Statement of Deficiencies and Plan of Correction in the spaces provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **November 12, 2013**. Failure to submit an acceptable PoC by **November 12, 2013**, may result in the imposition of civil monetary penalties by **December 2, 2013**.

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

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

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

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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 **November 15, 2013 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **November 15, 2013**. A change in the seriousness of the deficiencies on **November 15, 2013**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **November 15, 2013** includes the following:

Denial of payment for new admissions effective **January 11, 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 **April 11, 2014**, if substantial compliance is not achieved by that time.

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

If you believe these deficiencies have been corrected, you may contact Loretta Todd, R.N. or Lorene Kayser, L.S.W., Q.M.R.P., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0036; phone number: (208) 334-6626; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

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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 **October 11, 2013** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the noncompliance at the time of the revisit, if appropriate.

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

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

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

- BFS Letters (06/30/11)

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

This request must be received by **November 12, 2013**. If your request for informal dispute resolution is received after **November 12, 2013**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,



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

LKK/dmj
Enclosures

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

PRINTED: 01/21/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/11/2013
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NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCA TELLO	STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCA TELLO, 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 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the annual recertification and complaint investigation survey that was conducted at your facility October 7-11, 2013. This survey incorporates changes that resulted from the Informal Dispute Resolution (IDR) process.</p> <p>The surveyors conducting the survey were: Sherri Case, LSW, QMRP, Team Coordinator Nina Sanderson, LSW Amy Jensen, RN Becky Thomas, RN</p> <p>Survey Definitions: ADON - Assistant Director of Nursing Services BIMS - Brief Interview for Mental Status CNA - Certified Nursing Assistant CVA - Stroke D/C -Discontinue DNS/DON - Director of Nursing Services GERD - Gastroesophageal Reflux Disease LN - Licensed Nurse MDS -Minimum Data Assessment PRN - As needed RCM - Resident Care Manager SSD - Social Service Director</p>	F 000	<p>Preparation and execution of this Plan of Correction (PoC) is not an admission of guilt nor does the provider agree with the conclusions set forth in the Statement of Deficiencies rendered by the Bureau. The Plan of Correction is prepared and executed simply as a requirement of federal and state law. We maintain that the alleged deficiencies do not individually, or collectively, jeopardize the health and safety of our residents, nor are they of such character as to limit this provider's capacity to render adequate resident care. Furthermore, the provider asserts that it is in substantial compliance with regulations governing the operation and licensure of skilled nursing facilities, and this document, in its entirety, constitutes this providers claim of compliance.</p> <p>Completion dates are provided for the procedural procession purposes to comply with the state and federal regulations, and correlate with the most recent contemplated or accomplished corrective action. These dates do not necessarily correspond chronologically to the date the provider is under the opinion it was in compliance with the requirements of participation or that corrective actions was necessary.</p>	
F 157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>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</p>	F 157	<p>F157</p> <p>Resident Specific 1 of 9 sampled residents (#4) was affected.</p> <p>Other Residents Any resident with significant changes in physical status has the potential to be affected.</p>	12/11/13

RECEIVED
JAN 31 2014
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE ADMINISTRATOR	(X6) DATE 1/29/14
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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 157	<p>Continued From page 1</p> <p>deterioration in health, mental, or psychosocial 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 staff interview and record review it was determined the facility failed to immediately notify a resident's family member when the resident had a significant change in her physical status and was started on an antibiotic for an infection. This was true for 1 of 9 (#4) sampled residents. This failed practice had the potential for more than minimal harm if the resident had a life-threatening condition and/or required more aggressive treatment. Findings include:</p> <p>Resident #4 was admitted to the facility on 2/13/13 with multiple diagnoses to include,</p>	F 157	<p>F157 continued...</p> <p>Facility Systems In-service will be provided to all nursing staff regarding the prompt contact of a family member, including interested parties, of any resident that has experienced a significant change in status.</p> <p>Monitoring DNS/Designee will conduct a review of significant changes of any residents for the past 6 months to ensure family or legal guardian were notified in a timely manner. Administrator/Designee will conduct a review of incidents/accidents of any residents for the past 6 months to ensure family or legal guardian were notified in a timely manner.</p>	

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F 157	<p>Continued From page 2</p> <p>vascular dementia, CVA with hemiparesis, and RLS (restless leg syndrome).</p> <p>Resident #4's Annual MDS dated 9/5/13, coded in part the following:</p> <ul style="list-style-type: none"> * BIMS = 11 and identified the resident's cognition was, "Moderately impaired." * Total dependence on two staff for bed mobility, transfers, and toileting, * Functional limitation in range of motion to upper and lower extremity. <p>The facility provided nurse's notes that included the following documentation:</p> <ul style="list-style-type: none"> * On 8/3/13 at 10:40 p.m., "Aides providing cares to res[ident] at approx[imately] 2145 [9:45 p.m.] reported to nurse res[ident] has red area to thigh. This nurse noted large red area to lateral left thigh approx[imately] 15 cm x 9 cm hot to touch and hard... Rocephin 1 GM [gram] IM [intramuscular] x [times] 3 days then report to [Physician's name]." * On 8/4/13 at 11:35 p.m., Res cont[inues] Rocephin 1 GM [gram] IM for cellulitis... * On 8/5/13 at 2:40 p.m., "Daughter [Daughter's name] notified of cellulitis and of antibiotic therapy." <p>NOTE: Resident #4's daughter was not notified until more than 48 hours after the cellulitis was identified and the antibiotic was started.</p> <p>On 10/10/13 at 3:50 p.m., the DNS and ADON were interviewed related to the delay of notification to the resident's family member. In addition, the DNS was asked for the facility's policy on notification of family. The DNS and ADON said they would have to look into why it took 2 days to notify Resident #4's family</p>	F 157		

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F 157	Continued From page 3	F 157			
F 166 SS=D	<p>483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES</p> <p>A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interview, and review of facility Suggestion/Grievance/Compliment (SGC) forms, it was determined the facility did not ensure active efforts to resolve a grievance regarding restricting a resident from using a commode. This was true for 1 of 13 sampled residents (#6). This created the potential that the resident would experience humiliation related to not being allowed to use a commode to meet his toileting needs. Findings included:</p> <p>Resident #6 was admitted to the facility on 7/22/11 with multiple diagnoses to include, obstructive sleep apnea, pulmonary hypertension, GERD, and Diabetes type 2.</p> <p>A Suggestion/Grievance/Compliment (SGC) form, undated, documented in the SGC section 1, "Them (sic) taking away [Resident's name] ights to use the commode when he feels it's needed to have a BM (bowel movement). He gets bad cramps and gas and he feels he has to go more often than others, also because of the Miralax (laxative). [Resident's name] always has to go at</p>	F 166	<p>F166</p> <p>Resident Specific 1 of 13 sampled residents (#6) was affected.</p> <p>Other Residents No other residents were affected.</p> <p>Facility Systems In-service will be provided to all staff regarding resident rights and assisting residents in writing grievances.</p> <p>Resident #6 care plan has been changed to remove commode use limit. Resident #6 was informed of availability of staff to assist with grievance writing. Staff in-serviced to allow resident #6 to use commode as needed.</p> <p>Monitoring An audit will be conducted by the Administrator/Designee weekly X4 weeks then every other week X4 weeks then monthly X3 months to ensure all grievances are filled out completely and will check with residents to ensure grievance resolutions are acceptable. ADON has conducted a review of all care plans for accuracy. A review will be conducted by the DNS/Designee weekly X4 weeks then every other week X4 weeks then monthly X3 months then quarterly to ensure care plans are accurate and appropriate.</p>	12/11/13	

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F 166	<p>Continued From page 4</p> <p>least twice on morning shift and sometimes twice on evening shift. He feels he has to have a BM, but it's just a lot of gas and he also urinates and the aids get mad because they're pulled off the floor, and they think it's just because [Resident's name] needs to urinate, [Resident's name] states 'since they didn't let him on the commode this is the first time he's crapped his pants since jr high.' The "When did it happen" section documented 7/30 and 7/31/[13]. The "How do you want the SGC corrected" section documented the facility should not take away his right to use the commode when he "feels he has to have a BM or when needed." The form was signed by Resident #6 but was not dated.</p> <p>The SGC Resolution sheet documented "Office Use Only" and identified the grievance was filed by Resident #6 and was assigned to the DON. The "Description of Resolution" section documented, "[LN #15] counseled on approach with resident and his professionalism. LN assured me that he will maintain professionalism and provide resident with the independence and right he deserves." The form included an area, "Involved Parties are Satisfied with Resolution." The "Yes" or "No" box were not checked. The form was signed by the DON on 8/2/13 and LN #15 on 8/3/13.</p> <p>During a meeting with two surveyors on 10/9/13 at 10:50 a.m., Resident #6 stated the facility made him "do things" that were not required of other residents. Resident #6 stated he was told his Care Plan documented he could only be put on the commode once per shift. The resident stated he had tiny BMs in his pants 8-10 times in the past 4-6 months. Resident #6 stated he tries to hold it (BM) but it causes cramping. He stated</p>	F 166		
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F 166	<p>Continued From page 5</p> <p>he can use a bedpan at night after he is in bed but the "bedpan is small and I have a big butt." He also stated it was difficult to use a bedpan to have a BM as it was hard to "bear down." He stated someone had complained to the nurse about his need to use the commode so often and only "peeing." He was told it was a waste of time as it takes 2 people off of the hall and he could just use a urinal. Resident #6 stated he currently was only allowed to use the commode 1 time per 8 hour shift. The resident stated he does not always know if the cramps are due to the need to have a BM or gas. Resident #6 stated he may need to use the commode every couple of hours but usually 1/2 to 1 hour after meals.</p> <p>Resident #6's "Physician Order Report" (recapitulation) dated 10/1/13 included the resident "May use bedside commode."</p> <p>Resident #6's "Aide Report Sheet" documented: *Continent of bowel and bladder *1 person assist (handwritten was commode/urinal) *Toilet before/after meals, HS (hour of sleep) and PRN (as needed)</p> <p>Resident #6's Care Plan for "Risk for Urinary/Bowel incontinence," dated 5/27/13 and revised 8/19/13, included the resident was continent of urine/bowel and "is able to make needs known. Assist as needed."</p> <p>A temporary Care Plan, dated 8/25/13, with a Problem/Need/Strength of "Resident is continent but needs assistance with toileting due to: commode use and urinal use." Below this was "...Res [resident] to use commode once per shift. May use bedpan as often as res likes."</p>	F 166		
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F 166	Continued From page 6 On 10/10/13 at 5:10 p.m. the Administrator and DNS were interviewed about the resident's concerns. The Administrator stated he had no idea that Resident #6 was only "allowed" to use the bed side commode once a shift. The Administrator stated Resident #6 should be assisted to the commode whenever he asked to use it and it was not acceptable that the resident's care plan documented he could only use the commode once a shift. The facility failed to ensure Resident #6's grievance regarding the use of the commode was resolved.	F 166		
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on staff interview it was determined the facility failed to train the contracted dietary services and housekeeping/laundry services on how to identify abuse; who staff should report allegations of abuse to; and what constituted abuse and/or neglect. This failed practice had the potential to affect any resident who may be subject to abuse, neglect or misappropriation of funds including 13 of 13 sample residents (#1-13). Findings include:	F 226	F226 Resident Specific No specific residents were affected. Other Residents All residents in the facility have the potential to be affected. Facility Systems All employees that work in this facility will be trained in abuse identification and prevention practices and will attend BCU (behavioral Care Unit) training annually. Monitoring An audit will be conducted by the Administrator/Designee weekly X4 weeks then every other week X4 weeks then monthly X3 months of all new hires to ensure that they are being trained in abuse identification and prevention as well as attending BCU training.	12/11/13

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F 226	Continued From page 7 On 10/10/13 at 7:30 p.m., during the abuse task, the dietary manager (DM) was interviewed regarding the training that staff in the dietary department received related to identifying and reporting suspected abuse. The DM said the dietary department had not received any training during orientation or at any other time by the facility about abuse. On 10/10/13 at 7:40 p.m., the Administrator was interviewed about the lack of abuse training for the dietary department. The Administrator said the current dietary department and the housekeeping/laundry department staff had not participated in the BCU (behavioral care unit) training. The Administrator said the facility was working on a way to incorporate dietary, housekeeping, and laundry services in the BCU training.	F 226		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure offensive odors were not present and to provide a sanitary environment in the facility Beauty Shop, shower rooms, therapy room, and storage rooms. This had the potential to decrease the quality of life for 13 of 13 sampled residents (#1-13) and for any resident using Shower Rooms #1 and #5. Findings included:	F 253	F253 Resident Specific 13 of 13 sampled residents were affected. Other Residents Any residents using shower rooms #1 and #5, using a smoking apron or using the Therapy Gym, have the potential to be affected. Facility Systems Shower rooms #1 and #5 will be deep cleaned by housekeeping. All shower rooms will be put on a cleaning schedule. Staff will be in-serviced regarding cleaning shower chairs immediately after use. Houskeeping will add the Cape May linen closet, the Therapy Gym, the Cape Hatteras linen closet, The central supply closet on Cape Elizabeth, the oxygen storage room and the Cape Hatteras lift storage room to their schedule of floor cleaning.	12/11/13

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F 253	<p>Continued From page 8</p> <p>On 10/10/13 at 2:30 PM, the Director of Maintenance (DM) was present on the environmental tour, and the following were observed:</p> <ol style="list-style-type: none"> 1. Shower Room #1, located on Cape Hatteras Hall, contained a strong urine smell. A smoking apron smeared with dark brown smears which appeared like chocolate cake was found on the floor. A second smoking apron smeared with dark colored food stains was found hanging over the Emergency Pull Station. The DM was present and stated he smelled a strong urine smell in Shower Room #1 which should not be there. The DM also stated both smoking aprons were covered with food stains which looked like dark chocolate cake and needed cleaning. 2. Shower Room #5, located on the Kitchen Hall, contained a shower chair with dried urine on the seat. The floor contained dark brown debris and the vent in the ceiling contained dust and grime buildup. The DM stated, "that looks like urine on the shower chair and I would not want to touch it." 3. Room #35 on the Men's Unit contained a fan which had dirt and dust buildup located on the grill protecting the fan blades. 4. Men's Unit Dining Room contained smoking aprons, smeared with food and dirt. The DM stated he doesn't know how often the smoking aprons are cleaned and he would not want to wear one. 5. Clean Linen Storage Closet floor, located on the Men's Unit, contained multiple packets of Vitamin D & E Ointment, 	F 253	<p>F253 continued...</p> <p>The facility will identify which resident's have fans in their rooms and housekeeping will create a cleaning schedule for each of those fans identified. The resident smoking aprons will be put on a cleaning schedule to ensure they are appropriate for use. Staff will be in-serviced regarding proper cleaning and storage of smoking aprons. Maintenance will repair the 2 holes in Cape Hatteras linen room floor.</p> <p>Monitoring An audit will be conducted by the Administrator/Designee weekly X4 weeks then every other week X4 weeks then monthly X3 months of the floors in the above named areas. An audit will be conducted by the Administrator/Designee weekly X4 weeks then every other week X4 weeks then monthly X3 months of the smoking aprons. An audit will be conducted by the Administrator/Designee weekly X4 weeks then every other week X4 weeks then monthly X3 months of the fans in the residents rooms. An audit will be conducted by the Administrator/Designee weekly X4 weeks then every other week X4 weeks then monthly X3 months of the shower rooms and shower chairs.</p>	

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F 253	<p>Continued From page 9 plastic bags, paper towels and a large amount of dust bunnies comprised of lint, rubbish and debris.</p> <p>6. Therapy Gym floor contained dark colored pieces of dirt, dust and debris.</p> <p>7. Central Supply Closet floor, located on Cape Elizabeth, was found to contain lint, dust, along with pieces of trash which included paper and cardboard.</p> <p>8. Clean Linen Room floor, located on Cape Hatteras, was found to have a large accumulation of fine, dark brown dirt, which the DM stated was powdered cement. The floor also had two holes which were approximately 1" in diameter. The DM stated the plumber drilled holes on Cape Hatteras looking for leaks last week and the floor had not been cleaned. The DM did not state when or whether the holes would be repaired.</p> <p>9. Oxygen storage room floor, located on Cape Hatteras, contained pieces of dark brown dirt, paper, plastic bottle cap, 2 screws, broken O-Ring, and dust bunnies comprised of lint, rubbish and debris.</p> <p>10. Lift storage room floor, located on Cape Hatteras, contained dark brown dirt, paper, dust bunnies comprised of lint, rubbish and debris along with a 24 pack of Diet Coke. On top of the two dusty shredder bins, located in the lift storage room, were a 24 pack of Coke, an empty Fuze bottle, and a 20 oz. bottle of Coke.</p> <p>The Director of Maintenance (DM) was present and stated the floors in the facility were dirty and</p>	F 253		

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F 253	Continued From page 10 littered with dust, debris, rubbish and beverages. On 10/10/13 at 8:00 PM, the Administrator was informed of the above environmental concerns. No further information was provided.	F 253		
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; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and	F 272	F272 Resident Specific 2 of 13 sampled residents (#'s 2 & 4) were affected. Other Residents All residents with side rails have the potential to be affected. Facility Systems ADON assessed all current residents with side rails for safety and necessity. In-service will be provided to licensed nurses regarding importance of assessing for safety and necessity of side rails prior to implementation. Monitoring An audit will be conducted by the DNS/Designee weekly X4 weeks then every other week X4 weeks then monthly X3 months of all side rail assessments to ensure ongoing safety and necessity of side rail use.	12/11/13

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F 272	<p>Continued From page 11 Documentation of participation in assessment.</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 ensure an initial/periodic review for the use of side rails was completed for 1 of 13 (#4) sampled residents. In addition, the facility failed to ensure side rails were assessed for safety prior to use for 2 of 13 (#2 & 4) sampled residents. This had the potential for more than minimal harm if a resident became entrapped in the side rails and sustained serious injury and/or death Findings include:</p> <p>1. Resident #4 was admitted to the facility on 2/13/13 with multiple diagnoses to include, vascular dementia, CVA (stroke) with hemiparesis, and RLS (restless leg syndrome).</p> <p>Resident #4's Annual MDS dated 9/5/13, coded in part the following: * BIMS = 11 and identified the resident's cognition was, "Moderately impaired," * Total dependence on two staff for bed mobility, transfers, and toileting, * Functional limitation in range of motion (ROM) to upper and lower extremity.</p> <p>On 10/8/13 through 10/11/13 Resident #4's bed was observed to have 1/2 side rails on each side and both side rails were up at all times when the</p>	F 272		

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F 272	<p>Continued From page 12 resident was in bed.</p> <p>A facility provided document, "Physical Restraint Evaluation," for 1/2 side rails dated 9/5/13, coded in part the following:</p> <ul style="list-style-type: none"> * Transfer and locomotion - dependent on staff for transfers and required a mechanical lift, * Bed mobility limitations - dependent mobility, * Functional limitations/ROM - contractures of the left arm, hand, leg, and foot, * Balance and posture - Impaired balance, * Explain the impact on the resident - why is the device necessary - "Safety and mobility," * How will the device help the resident function better - "Assist [with] bed positioning," * Can the resident self-release the device on command - "No." <p>NOTE: Resident #4 was totally dependent on staff for bed mobility and transfers. The resident had left sided impairment and contractures in her left, arm, hand, and foot; however, the facility documented the side rails would assist the resident with bed positioning and mobility. In addition, the resident's medical record did not document the side rails had been assessed for safety and were safe to use.</p> <p>On 10/10/13 at 3:50 p.m. the DNS and ADON were informed and interviewed related to side rail use. The surveyor asked the DNS how the facility determined Resident #4 needed the side rails. The DNS said the facility uses a form, "Evaluation for the Use of Siderails" and it would be in the resident's medical record. The surveyor asked the DNS how the side rails would assist the resident with turning side to side; moving up and down in the bed; holding self to one side; pulling self from laying to sitting position; and exiting and</p>	F 272		
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F 272	<p>Continued From page 13</p> <p>entering the bed more safety. The DNS provided no further information, but said she would be checking into the use of the side rails.</p> <p>The only "Evaluation for the Use of Side Rails" located in the resident's chart was dated 8/4/13 and was for, "transfer bars X 2." The box indicating the transfer bars were safe for resident use was checked and the form was signed by the facility representative; however, no date was documented. The facility had not completed a new evaluation or determined the side rails were safe prior to placing them on the resident's bed on 9/5/13.</p> <p>2. Resident #2 was admitted to the facility on 4/1/13 with multiple diagnoses including multiple sclerosis.</p> <p>Resident #2's most recent Quarterly MDS assessment, dated 8/5/13, coded: -BIMS of 15, indicating the resident was cognitively intact. -Extensive assistance of 2 for transfers.</p> <p>On 7/2/13, an "Evaluation For the Use of Siderails" form for Resident #2 documented the use of siderails for assistance with bed mobility and transfers. There was an area on the form with an option to check that the siderails had evaluated as either safe, or unsafe, for the resident to use. Neither of these options was checked.</p> <p>On 10/7/13 at 4:30 PM, during the initial tour of the facility, Resident #2 was observed to have 1/2 siderails up on both sides of his bed. Resident #2 stated he used the siderails to help him move around in bed.</p>	F 272		
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F 272	Continued From page 14 On 10/10/13 at 4:45 PM, the DNS was asked about the safety assessment for Resident #2's siderails. The DNS stated, "I know. We missed it. We'll fix it." On 10/10/13 at 8:15 PM, the Administrator and DNS were informed of the surveyor's findings. The facility offered no further information.	F 272		
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. 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 needs that are identified in the comprehensive assessment. 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). This REQUIREMENT is not met as evidenced by: Based on individual and group resident interview, staff interview, and record review, it was	F 279	F279 Resident Specific 6 of 9 sampled residents (#s 1,2,4,6,7,9) were affected. Other Residents 6 of 13 sampled residents who attended the resident group interview had the potential to be affected. Facility Systems Social Service Department has developed a new tracking form to ensure timeliness of resident care conferences. Tracking form will also denote when resident and/or resident family or guardian were informed of care conference, response from resident and/or resident family or guardian whether they will be attending or not, date and time of conversation. Residents will receive a reminder just before their care conference to ensure they are aware of when it will be held. Monitoring A random audit will be performed by the Administrator/Designee weekly X4 weeks then every other week X4 weeks then monthly X3 months to ensure all resident's and/or resident family or guardian are invited to attend care conferences.	12/11/13

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F 279	<p>Continued From page 15</p> <p>determined the facility did not use the results of comprehensive interdisciplinary assessments, in conjunction with resident and family input, to develop, review, and revise resident care plans. This was true for 6 of 13 residents who attended the group meeting and 6 of 9 residents (Resident #s 1, 2, 4, 6, 7, and 9) sampled for resident input on care plans. This deficient practice had the potential to cause more than minimal harm when residents did not have input as to how their highest practicable physical, mental, and psychosocial well-being could be attained. Findings included:</p> <p>1.a. Resident #7 was admitted to the facility on 12/31/12 with multiple diagnoses including muscular dystrophy and bipolar disorder.</p> <p>Resident #7's most recent Annual MDS assessment, dated 3/1/13, coded:</p> <ul style="list-style-type: none"> -BIMS of 15, indicating no cognitive impairment. -Extensive assistance of 2 persons for transfers and bathing. -Extensive assistance of 1 person for dressing and hygiene. -Range of motion impairment in all extremities. <p>Resident #7's Care Area Assessments (CAAs), dated 3/1/13, triggered for care plan considerations for Activities of Daily Living, Urinary Incontinence and Indwelling Catheter, Falls, Nutritional Status, and Pressure Ulcers. In each of these categories, the area of the CAA for, "Input from resident and/or family/representative regarding the care area" documented, "no concerns."</p> <p>On 10/9/13 at 11:20 AM, the ADON was asked about Resident #7's CAAs. The ADON stated,</p>	F 279		
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F 279	<p>Continued From page 16</p> <p>"Well, he won't talk to me. I think he gets used to seeing me. To him I'm useless."</p> <p>On 10/10/13 at 2:30 PM, the surveyor met with Resident #7 regarding his input on his care plan. Resident #7 stated he had not been given the opportunity for input. The surveyor asked Resident #7 if perhaps he had been given the opportunity, but declined to have input. Resident #7 laughed and stated, "You know me better than that. I have lots of ideas."</p> <p>b. Resident #2 was admitted to the facility on 4/1/13 with multiple diagnoses including multiple sclerosis.</p> <p>Resident #2's most recent Annual MDS assessment, dated 8/5/13, coded: -BIMS of 15, indicating no cognitive impairment. -Extensive assistance of 2 for transfers, bathing, and hygiene. -Extensive assistance of 1 for dressing. -incontinent of bowel, had a catheter.</p> <p>Resident #2's CAAs, dated 4/30/13, triggered for care plan considerations for Cognitive Loss, Activities of Daily Living, Urinary Incontinence and Indwelling Catheter, Psychosocial Well-Being, Behavioral Symptoms, Falls, Nutritional Status, Dehydration/Fluid Maintenance, Pressure Ulcers, and Psychotropic Medication Use. In each of these categories, the area of the CAA for, "Input from resident and/or family/representative regarding the care area" documented, "no concerns."</p> <p>On 10/9/13 at 11:20 AM, the ADON was asked about Resident #7's CAAs. The ADON stated, "As far as I know, he has no concerns. But I have</p>	F 279			

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F 279	<p>Continued From page 17</p> <p>been getting some pointers on how to get more information on the CAAs."</p> <p>c. Resident #4 was admitted to the facility on on 2/13/13 with multiple diagnoses to include, vascular dementia, CVA with hemiparesis, and RLS (restless leg syndrome).</p> <p>Resident #4's most recent Annual MDS assessment dated 9/5/13, coded: - BIMS of 11 indicating moderate cognitive impairment, - Total dependence of two staff for bed mobility, transfers, and toileting, - Functional limitation in range of motion to upper and lower extremity.</p> <p>Resident #4's Care Area Assessment CAA's, dated 9/5/13, triggered care plan considerations for, cognitive loss, ADL function/rehabilitation potential, urinary incontinence, psychosocial well-being, behavioral symptoms, activities, falls, nutritional status, dental care, pressure ulcers, and psychotropic drug use. In each of these categories, the area of the CAA for, "input from the resident and/or family/representative regarding the care area documented, "No concerns."</p> <p>On 10/8/13 at 3:15 p.m., the surveyor met with Resident #4 related to her input on her care plan. Resident #4 stated she had not been given the opportunity to provide input. Resident #4 stated, "I just figured decisions about my care were left up to the doctors and nurses to make."</p> <p>On 10/10/13 at 3:50 p.m., the surveyor asked the DNS about Resident #4's CAAs. The DNS said she did not know if the resident had been asked</p>	F 279		

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NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO	STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCATELLO, ID 83201
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F 279	<p>Continued From page 18 to provide input or not related to the triggered areas on the CAAs. No additional information was provided.</p> <p>d. Resident #6 was admitted to the facility on 7/22/11 with multiple diagnoses to include, morbid obesity, obstructive sleep apnea, pulmonary hypertension, Schizoaffective disorder, and diabetes type II.</p> <p>Resident #6's most recent Annual MDS assessment, dated 5/23/13, coded:</p> <ul style="list-style-type: none"> - BIMS of 15, indicating no cognitive impairment, - Limited assist of 1 person for bed mobility, - Extensive assist of 2 people for dressing and personal hygiene, - Total dependence of 2 people for transfers and bathing. <p>Resident #6's CAAs, dated 5/23/13, triggered care plan considerations for, ADL function/rehabilitation potential, urinary incontinence/catheter, falls, nutritional status, pressure ulcers, and psychotropic drug use. In each of these categories, the area of the CAA for, "Input from resident and/or family/representative regarding the care" area documented, "No concerns."</p> <p>On 10/9/13 at 10:50 a.m., the surveyor met with Resident #6 regarding his input on his care plan. Resident #6 did not remember if the facility gave him the opportunity to provide input for his care plan. The resident said, "Staff listens to me, but do not change anything, they do not hear me."</p> <p>On 10/10/13 at 5:10 p.m., the Administrator and DNS were asked about Resident #6's CAAs. The Administrator and DNS did not know if the</p>	F 279		
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F 279	<p>Continued From page 19</p> <p>resident had been asked to provide input or not related to the triggered areas on the CAAs. No additional information was provided.</p> <p>e. Similar CAA findings for Resident's #1 and #9.</p> <p>2. On 10/8/13 at 9:30 a.m. a resident group interview was held with 13 residents attending the meeting with the surveyors. Residents were asked if they attended a meeting about their care plan. The resident's stated they did not understand the question. The surveyor explained the facility was required to invite them, or their family members, to attend a meeting to develop a plan identifying the care and services they (the residents) would receive. Five residents stated they had not been invited to a meeting regarding their care. Another resident stated he/she had attended a meeting a long time ago. Only 1 of the 13 residents stated they had been invited to a recent meeting regarding the care they were to receive.</p> <p>On 10/9/13 at 10:15 AM, the surveyor met with the SSD to discuss the facility's process for care plan meetings. The SSD stated in general, the facility would meet with a resident's family shortly after admission to find out about, "what they like and don't like." Then, through the process of interdisciplinary meetings such as Nutrition at Risk, the facility staff discussed issues regarding the residents and updated resident care plans. When asked specifically about ongoing care planning conferences with the residents, the SSD stated some of the resident families were very active, and some not at all. The SSD stated the facility was working on developing a form which could be filled out and sent to less active resident families following the care conference meeting.</p>	F 279		
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F 279	<p>Continued From page 20</p> <p>The SSD was asked if the residents themselves, not just resident families, were invited, encouraged, and assisted to attend care plan meetings. The SSD stated most, but not all, residents were invited. The SSD stated if a resident had a hearing deficit, for instance, profound enough to prevent understanding of the conference, they would not be invited to attend. The SSD had no documentation as to which residents were or were not invited to attend their care planning meetings.</p> <p>On 10/9/13 at 3:55 PM, the Administrator and DNS were asked about residents attending their own care plan meetings. The Administrator stated, "Well, it can be a challenge because of the type of facility we are (the facility has a large population of residents with behavioral challenges). When asked if the facility had employed strategies, such as having someone go over the agenda for the care conference with the resident in advance, so the resident would know what to expect, the Administrator stated, "We haven't done that. But it's something to consider."</p> <p>On 10/10/13 at 2:30 PM, the surveyor met privately with Resident #7, per his request, to follow up with some of the concerns discussed in the Resident group. Resident #7 stated he had never been invited to attend a care conference with facility staff, but he would like to do so. Resident #7 stated, "I have lots of ideas."</p> <p>On 10/9/13 at 10:50 a.m., during an interview with the surveyors, Resident #6 stated he decided if he wanted to attend his care plan meeting. Resident #6 stated if he does attend the meeting the facility "listens" to him but they do not "hear" him.</p>	F 279		
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F 279	Continued From page 21	F 279		
F 280 SS=D	<p>On 10/10/13 at 8:15 PM, the Administrator, DNS, and Facility Owner were informed of the surveyor's findings. The facility offered no further information.</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO 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 and record review it was determined the facility failed to ensure care plans were revised to reflect physician orders related to assistance with meals for 1 of 9 sampled residents (#1). This placed the resident at risk for choking or other swallowing related problems.</p>	F 280	<p>F280</p> <p>Resident Specific 1 of 9 sampled residents (#1) was affected.</p> <p>Other Residents No other residents were affected.</p> <p>Facility Systems In-service will be provided to all staff regarding reading and following each resident's care plan.</p> <p>Monitoring An audit will be conducted by the DNS/Designee weekly X4 weeks then every other week X4 weeks then monthly X3 months on all new physician orders to ensure care plans match the physician orders.</p>	12/11/13

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F 280	<p>Continued From page 22</p> <p>Findings included:</p> <p>1. Resident #1 was admitted to the facility on 11/29/10 with diagnoses that included Alzheimer's disease, dementia with behavioral disturbance, obstructive sleep apnea and insomnia.</p> <p>Resident #1's 10/2013 physician orders included, "When assisting resident with eating, alternate liquids with cold Magic cup to stimulate swallow."</p> <p>Resident #1's 7/30/13 Care Plan for "Choke Risk" had interventions of:</p> <ul style="list-style-type: none"> *One to one staffing *No concentrated sweets pure/thin liquid diet with double portions *Set up assist, supervision, assist with feeding and within arm's length *Resident does not have teeth and pockets his food *Small bites and sips, wait for him to swallow before next bite/sip, medications are crushed <p>Resident #1's 7/30/13 Care Plan for Weight Loss included he was to receive, "Supplements As Ordered."</p> <p>The resident's Care Plan did not include the physicians's order too alternate liquids with the Magic Cup to stimulate swallowing.</p> <p>During the evening meal observation, on 10/9/13 at 5:55 p.m., CNA #14 was observed assisting Resident #1 to eat. CNA was observed to give the resident bites of pureed chicken, pureed vegetable, mashed potatoes, two more bites of chicken and a drink of milk. After the milk CNA #14 gave the resident more food but was not observed (during the meal) to offer the resident a</p>	F 280		

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F 280	Continued From page 23 drink of his Magic Cup. The Administrator and the DON were informed of concerns regarding Care Plans not being revised on 10/10/13 at 8:00 p.m. The facility provided no further information.	F 280		
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, medical record review, and staff interview, it was determined the facility failed to ensure a resident received necessary treatment and services to prevent a venous ulcer from becoming infected and painful. This was true for 1 of 13 sampled residents. Resident #10 was harmed when a wound was not assessed, monitored and treated for at least 48 hours after it was identified. Additionally, the facility failed to ensure care plan interventions were implemented and there was communication with the dialysis treatment center. This affected 4 of 13 (#s 1, 9, 11, & 12) sampled residents. This practice created the potential for harm related to unmet resident care needs. Findings included: 1. Resident #10 was admitted to the facility on 9/24/13 with diagnoses that included a middle	F 309	F309 Resident Specific 1 of 13 sample residents (resident #10) was affected. Additionally, 4 of 13 sample residents (#1, 9, 11 & 12) were affected. Other Residents No other residents were affected by the issue with resident #10. Any residents with orders for Ted Hose have the potential to be affected by the issue with resident #9. No other residents were affected by the issue with residents #11 & #12. Facility Systems Upon discovery, the facility skin nurse provided the necessary assessment and treatment of resident #10's wound. In-service provided to licensed nursing staff regarding proper protocol of documentation and notification of Administration, Physician and family upon discovery of any new skin issues. In-service provided to all floor staff regarding immediate notification of nurses for any new resident skin issues discovered. Resident #10 chose to leave this facility of her own accord as of October 11th, 2013. Facility unable to complete corrective actions with this specific resident due to her departure. In-service will be provided to licensed nursing staff regarding proper documentation when medication is unavailable.	12/11/13

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F 309	Continued From page 24 cerebral artery stroke, coronary artery disease and osteoarthritis. a. Resident #10's medical record included an Admit Nursing Note (ANN), dated 9/24/13, which documented abrasions that were almost healed to the resident's right elbow and right lateral malleolus (prominence on the outer side of the ankle). The ANN documented no other skin issues. Skin Assessment forms for the resident documented the following: 9/24/13 & 9/25/13 - A small scratch to the top of the foot and an abrasion to the right elbow. The 9/224/13 Skin Assessment documented in the Comments section, "Rest of skin looks good." 9/30/13 - Abrasion right elbow, scratch middle of right foot and lesion venous 5 cm by 3 cm (area of right inner lower leg marked on diagram) -MD notified, antibiotic started, culture of wound. NOTE: Resident #10's Physician Order Flow Sheet documented the following was initiated on 9/30/13: At midnight: Lorazepam .5 mg IM (intramuscular injection) now At 7:00 PM: Culture right lower leg ulcer At 7:00 PM: an antibiotic, Minocia, 100 mg every day for the right lower leg ulcer At 7:00 PM: Clean right lower leg...Apply Bacitrin to area 10/7/13 - Bruise to right arm with small abrasion and unaboot (treatment for venous stasis ulcer). Wound or Pressure Sore Identification and Progress Records documented the following: 9/30/13 - The diagram had the right lower inner leg marked. Non-stageable, size 5.0 cm by 3.0 cm with moderate green drainage, odor, macerated with rolled edges. Pain and infection at the site were marked "yes." The wound type	F 309	F309 continued... In-service will be provided to all staff regarding ensuring all Ted Hose orders are being followed. In-service provided to licensed nursing staff regarding proper use and documentation of dialysis communication forms. Monitoring Facility skin team has conducted updated skin assessment on all the residents in the facility. Facility skin team will conduct follow up skin assesments on all residents weekly X4 weeks then every other week X4 weeks then monthly X3 months then monthly spot checks. Within 24 hours of resident admission or resident incident/accident report, DNS/Designee will perform a follow up skin assessment weekly X4 weeks then every other week X4 weeks then monthly X3 months. An audit will be conducted by the DNS/designee weekly X4 weeks then every other week X4 weeks then monthly X3 months to ensure residents with orders for protective items are being used and properly being used according to the orders. An audit will be conducted by the DNS/designee weekly X4 weeks then every other week X4 weeks then monthly X3 months of all new therapy orders to ensure they are being implemented properly. An audit will be conducted by the DNS/designee 3 times a week X2 weeks then weekly X2 weeks then every other week X4 weeks then monthly X3 months of dialysis communications forms to ensure they are completed and up to date.		

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F 309	Continued From page 25 was identified as "venous"Change in plan of care and new orders. 10/7/13 - (Same diagram as above) Non-stageable, 5.0 cm by 4.0 cm, moderate green yellow drainage, macerated with rolled edges. Pain and infection were documented. Started on another antibiotic and hyperbarics (oxygen wound therapy). Daily Wound Assessment Forms dated 10/5/13, 10/6/13, 10/8/13 and 10/9/13 documented pain was present. The 10/6/13 assessment documented the pain was not adequately controlled. Resident #10's Nurses Notes (NN) from 9/24/13 through 9/29/13 did not document a wound to the right lower leg. A 9/30/13 NN documented the resident's daughter asked the nurse to evaluate the mother's leg. The right "lower calf to be red, weepy, wound open, area cleansed..." The physician and wound nurse were notified. NNs from 9/30/13 document drainage and dressing changes to the wound. NN dated 10/6/13 documented an appointment would be made with the wound clinic. A 10/7/13 NN documented the resident returned from Hyperbarics with a "UNA boot." No new orders received, call placed to hyperbarics by the nurse—they stated they will fax by end of day. NNs from 10/8/13 - document the use of an anti-biotic and weekly appointments at the wound clinic. The resident's 9/30/13 "Skin Problem Actual" care plan documented a venous insufficiency ulcer to the right lower leg. Approaches included daily evaluation of dressing status and surrounding area, weekly assessments with measurements and to culture the wound. NOTE: There was no care plan related to a wound on the right lower	F 309			

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F 309	<p>Continued From page 26 leg prior to 9/30/13. On 10/10/13 at 3:15 p.m., the DON stated Resident #10 was admitted to the facility (9/24/13) with a scab on her "right inner mid calf." The resident's daughter asked the nurse to apply a dressing to the "scab." The bandage remained on the wound for 48 hours prior to a family member requesting the facility check the wound due to drainage. When the nurse checked the wound, on 9/30/13, it was large and appeared to be infected. The physician was called and ordered an antibiotic and to be cultured. The surveyor asked the DON if the wound should have been checked prior to the daughter requesting the wound be assessed. The DON stated yes. The DON stated based on observation of the wound and information from the hyperbaric report the wound was determined to be a venous ulcer. The surveyor stated concern the facility had not identified the drainage or assessed the wound prior to the family member observing the drainage. The DON was asked for documentation the resident was admitted with the wound and the DON stated she would check for documentation the scab was present when the resident was admitted. The surveyor requested the facility complete a time line to identify when the daughter requested a dressing be applied to the scab and the treatment provided. The time line identified the facility applied a dressing to the wound on 9/27/13 (No time identified). On 9/30/13 at 7:00 PM the resident's daughter asked staff to remove the dressing and new physician orders were received for treatment to the lower leg. On 10/18/13 the facility provided a fax which included a 10/1/13 NN that stated it was a "Late entry from 9/28/13." It documented that the resident's family member was visiting and noticed</p>	F 309		
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F 309	<p>Continued From page 27</p> <p>a wound on the resident's right inner ankle (NOTE: All other entries in the record refer to the calf or lower leg.) The wound was "approx[imately] 1cm X .5 mg (? cm)" with two lines...scabbed and shriveled edges that appeared to be healing..." family member "was in insistant that this nurse put a bandange on the wound in case she bumped it..." The late entry was on a separate NN and was not included in the above mentioned NN between 9/30/13 and 10/2/13.</p> <p>The resident was harmed when a wound deteriorated significantly as the result of the facility's failure to document, assess and monitor a wound that was identified by a family member 2 or 3 days prior to physician notification. he DON's timeline indicated the scabbed wound was first noted on 9/27/13, while the Late Entry NN indicated the conversation with the family member occurred on 9/28/13. No care plan was developed and there was no indication of assessment and/or monitoring until 9/30/13 at 7:00 PM when once again the family member expressed concern about this wound. The wound on the right lower calf was noted to be red, weepy, and open. The resident experienced pain and the need for antibiotics and hyperberic treatment as a result of this delay in treatment.</p> <p>b. Resident #10 medical record included a telephone physician order dated 10/3/13 for Boniva 150 mg every month. The resident's Physician Order Flow Sheet documented the resident did not receive the medication until 10/8/13.</p> <p>On 10/10/13 at 3:15 p.m. the DON was asked about the above concern. The DON stated the resident's discharge orders from the hospital did not include an order for Boniva. The daughter brought in the medication and informed the facility</p>	F 309		
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F 309	<p>Continued From page 28</p> <p>the resident usually took the medication around the 1st of the month. The facility contacted the physician and the telephone order was received. On 10/11/13 at 10:45 a.m. the DON and Administrator were informed the resident had not received the medication for 5 days after the order was received. The facility provided no further information.</p> <p>2. Resident #9 was admitted to the facility on 9/5/12 with diagnoses that included psychosis, anxiety, edema and dementia.</p> <p>Resident #9's 10/13 Physician Order Report (recapitulation orders) included the resident was to have TED hose on, " in AM and off at HS [Hour of sleep]."</p> <p>The resident's 7/23/13 care plan for Dressing/Grooming included "Ted hose on in AM off in PM for Edema."</p> <p>During observations on 10/8/13 at 9:05 a.m., 2:20 p.m. and 3:10 p.m. the resident was observed in shorts without TED hose on. On 10/9/13 at 7:20 a.m. and 9:00 a.m. the resident was without TED hose as well.</p> <p>On 10/10/13 at 3:15 p.m. the DON stated the resident should have had his TED hose on during the above observations.</p> <p>3. Resident #1 was admitted to the facility on 11/29/10 with diagnoses that included Alzheimer's disease, dementia with behavioral disturbance, obstructive sleep apnea and insomnia.</p> <p>Resident #1's 10/2013 physician orders included "When assisting resident with eating, alternate</p>	F 309		
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NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO	STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCATELLO, ID 83201
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F 309	<p>Continued From page 29</p> <p>liquids with cold Magic cup to stimulate swallow."</p> <p>Resident #1's medical record included an "In-Service Record", dated 10/10/13 that documented, "When assisting (Resident's name) with eating, alternate between bites of food and magic cup to stimulate swallowing."</p> <p>During the evening meal observation, on 10/9/13 at 5:55 p.m., CNA #14 was observed assisting Resident #1 to eat. CNA was observed to give the resident bites of pureed chicken, pureed vegetable, mashed potatoes, two more bites of chicken and a drink of milk. After the milk CNA #14 gave the resident more food but was not observed (during the meal) to offer the resident a drink of his Magic Cup.</p> <p>4. Resident #12 was admitted to the facility on 12/19/11 with multiple diagnoses including End Stage Renal Disease.</p> <p>Resident #12's most recent Annual MDS assessment, dated 8/22/13, coded Resident #12 received dialysis services while a resident in the facility.</p> <p>Resident #12's Physician's Order Report (recapitulation orders) for October 2013 documented, "Dialysis Mon, Wed, Fri."</p> <p>Resident #12's record included Dialysis Communication Forms. The forms included areas for the facility to indicate which medications Resident #12 had received prior to dialysis, the condition of her skin, and any treatment changes since the date of her last dialysis. The forms also included areas for dialysis to communicate back</p>	F 309		
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F 309	<p>Continued From page 30</p> <p>to the facility Resident #12's weight before and after dialysis, any special instructions following dialysis treatment, any medications administered during dialysis, and any recommendations from the dialysis center. Between 8/2/13 and 10/10/13, Resident #12 was scheduled for dialysis on 30 occasions. However, there was a communication form between the facility and dialysis on only 15 of those occasions. Additionally, of the 15 forms present, 10 of them were completely blank in the areas for the dialysis center to communicate information back to the facility.</p> <p>5. Resident #11 was admitted to the facility on 10/20/12 with diagnoses that included diabetes mellitus, chronic kidney disease and atrial fibrillation.</p> <p>Resident #11's most recent Annual MDS assessment, dated 10/2/13, coded Resident #11 received dialysis services while a resident in the facility.</p> <p>Resident #11's Care Plan for complications related to Dialysis documented "Dialysis Monday, Wednesdays and Fridays."</p> <p>Resident #11's record included Dialysis Communication Forms. The forms included areas for the facility to indicate which medications Resident #11 had received prior to dialysis, the condition of her skin, and any treatment changes since the date of her last dialysis. The forms also included areas for dialysis to communicate back to the facility Resident #11's weight before and after dialysis, any special instructions following dialysis treatment, any medications administered during dialysis, and any recommendations from the dialysis center. Between 8/2/13 and 10/7/13,</p>	F 309		
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F 309	Continued From page 31 Resident #11 was scheduled for dialysis on 30 occasions. However, there was a communication form between the facility and dialysis on only 15 of those occasions. Additionally, of the 15 forms present, 2 of them were completely blank in the areas for the dialysis center to communicate information back to the facility. On 10/10/13 at 2:30 PM, the surveyor asked the DNS about the dialysis communication forms for Resident #11 and Resident #12. The DNS stated the forms were used to communicate information between the facility and the dialysis center with each dialysis treatment. The DNS was informed the surveyors had found some forms for Resident #11 and Resident #12 to be either incomplete, or missing altogether. The DNS stated she may have some of the more recent forms in a notebook for her review before filing, but she would have to look. After looking, the DNS was not able to produce the missing or incomplete documentation. On 10/10/13 at 8:15 PM, the Administrator, DNS, and Facility Owner were informed of the surveyor's findings. The facility offered no further information.	F 309			
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323	F323 Resident Specific No specific residents were affected. Other Residents All residents have the potential to be affected. The Buff Mop On Dressing Spray has been removed from shower room #5 and the cabinet has been locked.	12/11/13	

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F 323	Continued From page 32 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure the safety of residents from accidents including an unlocked storage cabinet containing a harmful chemical. This was true for any resident using Shower Room #5. Findings included: On 10/10/13 at 3:15 PM, during the Environmental Tour, the storage cabinet in Shower Room #5 was observed to be unlocked with the lock dangling from a coiled cord attached to the storage cabinet. The storage cabinet contained a bottle of Buff Mop On Dressing Spray. The spray bottle label contained an HMIS (Hazardous Materials Identification System) warning. The DM was present and stated the storage cabinet should be locked and the spray bottle should not be in the cabinet. On 10/10/13 at 8:00 PM, the Administrator was informed of the above environmental concerns. No further documentation was provided.	F 323	F323 continued... Facility Systems In-service will be provided to all staff regarding chemical use in shower rooms and proper use and storage of supplies in shower room cabinets. Monitoring An audit will be conducted by the Administrator /Designee weekly X4 weeks then every other week X4 weeks then monthly X3 months to ensure shower room cabinets are locked properly and shower room chemicals are stored in the proper place.		
F 329 SS=D	483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.	F 329	F329 Resident Specific 1 of 9 sampled residents (#9) was affected. Other Residents All residents on antipsychotic medications have the potential to be affected. Facility Systems ADON reviewed resident #9's drug regime with physician to obtain justification for duplicate therapy.	12/11/13	

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F 329	<p>Continued From page 33</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility did not ensure that each resident's medication regimen was free from unnecessary drugs, specifically duplicate therapy. This was true for 1 of 9 sample residents (#9) and created the potential for unwanted side effects when the resident received two antipsychotic medications without clinical indication of need.</p> <p>Resident #9 was admitted to the facility on 9/5/12 with diagnoses that included psychosis, anxiety, edema and dementia.</p> <p>Resident #9's 10/1/13 Physician Order Report (recapitulation orders) included an order for Seroquel (antipsychotic) 50 mg at hour of sleep for psychosis with a start date of 3/15/13 and an order for Zyprexa (antipsychotic) 5 mg at hour of sleep for psychosis.</p> <p>The resident's medical record did not include</p>	F 329	<p>F329 continued...</p> <p>Monitoring An audit will be conducted by the ADON weekly X4 weeks of antipsychotic medications to ensure any duplicate therapy has physician justification. This audit will continue weekly during our psychotropic drug review meeting every Friday, indefinitely.</p>	

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F 329	Continued From page 34 physician justification for the use of two medications from the same pharmacological class. On 10/10/13 at 3:15 p.m. the DON was asked for the physician justification for the duplicate therapy. She stated she would look for the documentation. No further information was provided by the facility.	F 329		
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on input from the Resident Group Interview, test tray evaluation, and staff interview, it was determined the facility did not ensure food was served at a palatable texture and level of doneness. This was true for 5 of 13 residents in resident group. The deficient practice had the potential to cause more than minimal harm if residents experienced a negative impact on their nutrition or psychosocial well-being from unpalatable food. Findings included: On 10/8/13 at 9:30 AM, the resident group identified the following concerns with the food served in the facility: -Beans, potatoes, and pasta were frequently undercooked. -Meat was frequently tough.	F 364	F364 Resident Specific 5 of 13 sampled residents in the resident group were affected. Other Residents All residents have the potential to be affected. Facility Systems In-service of all dietary staff regarding the importance of quality and properly cooked food. Monitoring Test trays will be audited by the Administrator/Designee weekly X8 weeks then monthly thereafter. Dietary Manager will randomly hold a food satisfaction survey audit 3 times per week X2 weeks then weekly thereafter immediately after meals to get feedback from residents about food quality. Resident council notes are being reviewed monthly after each council session by Social Services to identify any ongoing or new dietary issues. Any dietary issues will be addressed immediately with the dietary manager and reported back to the resident council president with any corrective action.	12/11/13

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F 364	<p>Continued From page 35</p> <p>-Food was at times cold.</p> <p>On 10/8/13 at 11:45 AM, during the noon meal observation, Resident #13 called the surveyor to his table and suggested they try the noodles being served with the noon meal as an example of undercooked pasta being served.</p> <p>On 10/8/13 at 12:00 noon, the surveyors, along with the Dietary Manager (DM), sampled a test tray. The tray included Swiss steak with gravy, parsleyed noodles, Brussel sprouts, a roll with margarine pudding, and milk.</p> <p>- The temperature of the Swiss steak was 148 degrees Fahrenheit (F). The steak was easily cut with a fork, moist, and flavorful.</p> <p>-The temperature of the Brussel sprouts was 141 F. They were fully cooked and soft.</p> <p>-There were no concerns with the milk, roll, or pudding.</p> <p>-The temperature of the noodles was 132 F. Three surveyors sampled the noodles, and found them to be undercooked. The noodles were crunchy to the point of being difficult to cut with a fork and knife. When chewed, the noodles broke apart into small shards of hardened dough, catching in the surveyors' teeth. There was an audible crunch as the noodles were chewed.</p> <p>After the surveyors sampled the test tray, the DM was asked about the texture and doneness of the noodles. The DM stated, "I think they are good." When asked if the noodles were cooked thoroughly enough, the DM stated, "I think they are."</p> <p>On 10/10/13 at 8:15 PM, the Administrator, DNS, and Facility Owner were informed of the surveyor's findings. The facility offered no further</p>	F 364		
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F 364	Continued From page 36 information.	F 364		
F 371 SS=F	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure food was prepared, stored, and served under sanitary conditions. This was true for 11 of 11 sampled residents (Resident #s 1-11), and any resident eating food prepared in the facility's kitchen. This failed practice created the potential for contamination of food and exposed the residents to potential sources of disease causing pathogens. Findings included: 1. On 10/7/13 at 3:40 PM, the following was observed during the initial tour of the kitchen:</p> <p>a. A metal sheet tray was in the walk-in cooler, with approximately 15 small fluted bowls filled with a white semi-liquid substance. The bowls were uncovered, with the contents exposed. There were boxes of prepared food items on the shelf directly above the exposed bowls. Cook #2 identified the substance in the bowls as pureed cookies, to be served with the meal that evening.</p>	F 371	<p>F371</p> <p>Resident Specific 11 of 11 sampled residents were affected.</p> <p>Other Residents All residents have the potential to be affected.</p> <p>Facility Systems In-service will be provided to all dietary staff regarding - covering, labeling and dating of foods; storing of clean dishes separate from dirty dishes; any food knocked on the floor not to be used or placed back with other food; tray cart checked to ensure it is free from debree before proceeding to tray line area; proper placement of soiled linens. In-service will be provided to all non-dietary staff regarding use of hairnets when entering the kitchen area. Maintenance Department to check freezer weekly for ice buildup and to remove any observed ice buildup until the new freezer is installed as part of the facility remodel. Bag of food covered with black ice was discarded.</p>	12/11/13

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F 371	<p>Continued From page 37</p> <p>When questioned about whether or not the bowls should be covered, Cook #2 stated, "I didn't know that had to be done."</p> <p>b. The walk-in freezer had a sheet of ice approximately 1" [inch] thick covering the entirety of the floor. There was a frost build-up approximately 1/2" thick, with approximately 1/2" of ice underneath, on the pipes leading from the compressor, the top 2 feet of the walls of the freezer, and the top two shelves on the left-hand side of the freezer. A sealed brown paper bag was on the top shelf. The bag was covered with 1" round splotches of black ice, each with a pyramid of frost approximately 1" high. The bag was identified by Cook #2 as french fries. When asked if the french fries would be used, Cook #2 stated, "Yes, unless you think I shouldn't." At the request of the facility's owner, the surveyor looked at the freezer again on 10/10/13 at 12:10 PM, assured the freezer was clean. At that time, the frost had been cleaned from the top two shelves, but the layer of ice which had been underneath the frost remained. The bag of french fries was no longer present. An area of frost build-up approximately 4" X 6" remained on the back wall of the freezer, just below the left side of the compressor. The pipes leading from the compressor were covered with a layer of frost. The sheet of ice no longer covered the floor.</p> <p>The 2009 FDA Food Code Chapter 4 Equipment, Utensils, and Linens, 4-6 Cleaning of Equipment and Utensils, subpart 4-601 Objective, 4-601-11 Equipment, Food-Contact surfaces, Nonfood-contact surfaces, and Utensils specified, "... (C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris."</p>	F 371		
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F 371	<p>Continued From page 38</p> <p>c. The 3 compartment ware washing sink nearest the food prep area had dishes identified as clean by Cook #2 (2 metal pitchers and a metal sheet pan) air-drying on the designated "clean" area to the right of the sanitizer area. While the surveyor observed, Cook #3 washed a large industrial can opener, rinsed and sanitized it, then placed it in the "clean" area to dry as well. However, the "clean" area also contained 2 small square plastic food containers, an ice cream scoop, a food processor and blade, and a wire whisk, all with visible food debris on and in them. Cook #2 identified those items as "dirty." When asked if the dirty dishes should be sitting in the area for clean dishes, Cook #2 stated, "I don't see why not."</p> <p>On 10/7/13 at 4:00 PM, the CDM was informed of the surveyor's observations. The CDM stated, "No. That's not OK."</p> <p>Federal guidance at F371 specifies, "...dishes, utensils, pots/pans, and equipment ...These items should be stored in a clean dry location and not exposed to splash, dust or other contamination ..."</p> <p>2. On 10/10/13 at between 11:25 AM and 12:20 PM, the following was observed during the tray line service:</p> <p>a. At 11:40 AM, Dietary Aide #5 knocked 2 small fluted bowls with individual servings of dessert (brownie), from the serving table onto the floor. Dietary Aide #5 picked up the containers of dessert and placed them back on the serving table, along with other containers of dessert. The CDM identified the containers of desserts as</p>	F 371		

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F 371	<p>Continued From page 39</p> <p>ready to served. The CDM was informed of this observation, picked up the 2 desserts, and set them on top of another tray of desserts identified as ready to serve. The CDM was then informed by the Dietary Consultant to destroy both trays of dessert.</p> <p>b. At 11:25 AM as the surveyor entered the kitchen area, an empty food serving cart was observed just inside the southern most door of the kitchen. A long curly blonde hair, approximately 12" in length, was adhered to the upper left hand corner of the cart. At 11:35 AM, Dietary Aide #5 retrieved the cart, brought it to the food serving area, and began to load trays onto the cart. Prior to the first tray being placed in the cart, the surveyor asked the CDM about the hair adhered to the cart. The CDM donned her eyeglasses, plucked the hair from the cart, and stated, "Well, it's not a food contact surface."</p> <p>c. At 11:45 AM, CNA #6 entered the kitchen area without wearing a hairnet. Her hair was unsecured, and extended to the middle of her back. The CNA approached the food serving line, asked for bananas, silverware, and condiments, and stood for approximately 30 seconds in the food serving area with unrestrained hair while those items were retrieved. This was repeated by CNA #7 at 11:55 AM. The CDM was asked if this was acceptable behavior. The CDM stated, "No. But it's really hard to control."</p> <p>d. At 11:50 AM, Dietary Aide #5 removed her visibly soiled apron and placed it on the bottom shelf of the dessert serving table, between a tray filled with plastic glasses and a tray filled with plastic bowls. Dietary Aide #5 exited the kitchen, then returned approximately 30 seconds later, picked up the apron, and placed it over her</p>	F 371			

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F 371	Continued From page 40 clothes. The CDM identified the tray of glasses and bowls as clean and ready to use. When asked if it was acceptable to place a soiled apron on the shelf with those items, the CDM stated, "No." On 10/10/13 at 8:15 PM, the Administrator and DNS were informed of the surveyor's findings. The facility offered no further information.	F 371			
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and	F 431	F431 Resident Specific No residents were affected. Other Residents All residents have the potential to be affected. Facility Systems Night nurse responsibilities will be updated to include weekly checks of medication carts, refrigerators and med room for expired medications and medications of discharged residents, ensure all medications are properly labeled. In-service provided to all nursing staff regarding removing and disposing of expired medications and ensurance of proper medication labeling. Monitoring An audit will be conducted by the DNS/Designee weekly X4 weeks then every other week X4 weeks then monthly X3 months of all medication carts and the medication room to ensure all expired medications are disposed of properly and in a timely manner, and to ensure proper labeling of medications.	12/11/13	

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F 431	<p>Continued From page 41</p> <p>Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to label medications and to ensure expired medications were removed from the medication room refrigerator and medication carts. This was true for 2 of 3 medication carts and 1 refrigerator checked for expired medications. This failed practice created the potential for decreased efficacy for any resident who could have received the expired medication. Findings include:</p> <p>1. On 10/9/13 at 8:40 AM, the following expired medications were found in the Cape Hatteras Medication Cart:</p> <ul style="list-style-type: none"> *1 tube of Proctozone HC 2.5%, expired 8/26/12. *Promethegan 25 mg Suppositories x 4, expired 9/27/12. *1 tube of Triamcinolone 0.1% Ointment, expired 8/25/13. *Promethegan 25 mg Suppositories x 6, expired 6/4/13. *1 bottle of Deep Sea Premium Saline, expired 2/2013. *1 can (13oz) Natural Fiber Powder - Safe Haven stock, expired 7/2013. <p>On 10/9/13 at 8:55 AM, LN #18 stated the med cart should have been checked for expired meds</p>	F 431	

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F 431	<p>Continued From page 42 and the expired meds should have been discarded.</p> <p>2. On 10/9/13 at 10:10 AM, the following expired medications were found on Cape Hatteras in the resident medication refrigerator.</p> <p>*Procrit 10,000 Units/ml, 4 vials, 2 ml each, expired 10/2/13. *Procrit 20,000 Units/ml, 5 vials, 1 ml each, expired 9/17/13.</p> <p>On 10/9/13 at 10:20 AM, LN #18 stated the expired meds in the refrigerator should have been discarded. LN #18 stated the Procrit was now being administered at dialysis and the facility was no longer administering this medication. LN #18 stated she would discard the expired medications with another nurse.</p> <p>3. On 10/9/13 at 10:30 AM, the following expired medications were found in the Cape May Medication Cart along with two tubes of medication which did not contain a label:</p> <p>*Two tubes of Oral Glucose 45 Gel, expired 7/2/13, Safe Haven stock. *1 Can (13 oz.) Natural Fiber Powder, expired 7/2013, Safe Haven stock. *1 tube of Triamcinolone Acetonide Ointment (80 gm) without a label. *1 tube of Mupirocin Ointment USP 2% (22 gm) without a label.</p> <p>On 10/9/13 at 10:40 AM, LPN #17 stated the expired medications should have been discarded and the Triamcinolone Ointment and Mupirocin Ointment should have been labeled. LPN #17 stated she would discard the expired</p>	F 431			

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F 431	Continued From page 43 medications. She stated she would reorder the Triamcinolone and Mupirocin Ointments from the pharmacy and would make sure they had the appropriate label for each resident. On 10/10/13 at 8:15 PM, the Administrator and DON were made aware of the expired medications found in the medication refrigerator located on Cape Hatteras and on the medication carts located on Cape Hatteras and Cape May. No further documentation or information was provided by the facility.	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions	F 441	F441 Resident Specific 1 of 13 sampled residents (#4) was affected. Other Residents All residents have the potential to be affected. Facility Systems In-service provided to all staff regarding proper hand washing protocol and the importance of hand washing as an infection control measure. In-service provided to all staff regarding proper handling of soiled linens. In-service provided to all staff regarding proper procedure for cleaning and re-making residents beds to avoid infection control issues. Monitoring An audit will be conducted by the DNS/Designee weekly X4 weeks then every other week X4 weeks then monthly X3 months to ensure staff are washing their hands properly. An audit will be conducted by the DNS/Designee weekly X4 weeks then every other week X4 weeks then monthly X3 months to ensure staff are making resident beds correctly.	12/11/13

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F 441	<p>Continued From page 44</p> <p>from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, review of a facility provided document related to handwashing, and resident and staff interview, it was determined the facility failed to ensure staff washed their hands after each direct resident contact for which hand washing was indicated and to store soiled linen in such a way as to minimize contamination. This was true for 1 of 13 (#4) sampled resident and 1 of 3 (Cape Hatteras) soiled linen closets. Failure to follow standard infection control measures placed the residents at risk for infections. Findings include:</p> <p>1. Resident #4 was admitted to the facility on 2/13/13 with multiple diagnoses to include, vascular dementia, CVA with hemiparesis, and RLS (restless leg syndrome).</p> <p>Resident #4's Annual MDS dated 9/5/13, coded in part the following: * BIMS = 11 indicating the resident's cognition was, "Moderately impaired," * Total dependence on two staff for bed mobility,</p>	F 441		

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F 441	<p>Continued From page 45 transfers, and toileting, * Functional limitation in range of motion to upper and lower extremity.</p> <p>A facility provided document, dated August 2002, Handling Infectious Waste documented the following related to hand washing: "Wash your hands thoroughly with soap and water at the following intervals, before a procedure; before resuming the procedure or after an interruption (assisting another resident and toileting...); when changing/removing gloves or any personal protective equipment; and upon completion of your task..."</p> <p>On 10/8/13 at 4:40 p.m., CNA's #9 and #13, were observed providing peri-care to Resident #4. CNA's #9 and 13 applied clean gloves, rolled the resident on her left side and removed the resident's wet incontinent brief. The resident's wound dressing was saturated with urine and required a new dressing. CNA #9 removed her soiled gloves and left the resident's room to find a nurse. CNA #9 did not wash her hands prior to leaving the resident's room.</p> <p>- 4:43 p.m., CNA #9 returned with LPN #16, and CNA and LPN applied clean gloves. Neither one washed their hands. LPN #16 removed the wet dressing from Resident #4's left gluteal fold, cleansed the area, removed the soiled gloves, did not wash her hands and then applied clean gloves.</p> <p>- 4:49 p.m., As LPN #16 applied the new dressing to the resident's gluteal fold the resident began to void. CNA's #9 and #13 with gloved hands removed the wet fitted sheet and incontinent pad. Then CNA #13, with wet linen in her hands, left the resident's room, opened the door to the dirty linen closet, placed the wet linen in the linen</p>	F 441		

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F 441	<p>Continued From page 46</p> <p>barrel, and returned to the residents room with the soiled gloves still on.</p> <p>- 4:50 p.m., With the soiled gloves on CNA #13 reached into her pants pocket and removed a garbage bag. CNA #9 and CNA #13 used a mechanical lift to move Resident #4 into the resident's wheel chair.</p> <p>- 4:55 p.m., CNA's #9 and #13 discarded their soiled gloves, but did not wash their hands. CNA # 13 brushed the resident's hair and picked up the resident's water mug and placed it by the resident in the wheel chair. CNA #13 applied splints to Resident #4's right and left wrist, and then applied the resident's head band and glasses. CNA #9 discarded her soiled gloves, but did not wash her hands and was observed walking into another resident's room.</p> <p>- 5:00 p.m. CNA #13 did not wash her hands, and then assisted the resident in the wheel chair to the nurse's station. CNA #13 removed clean linen from the linen closet, returned to Resident #4's room and placed clean sheets on the resident's bed without cleaning the mattress first, which still had urine on it.</p> <p>- 5:10 p.m. CNA #13 asked Resident #4's roommate if she needed anything, then the CNA washed her hands, and left the room.</p> <p>On 10/8/13 at 6:30 p.m., CNA's #9 and #13 and the DNS were interviewed about the above observation. The CNA's said they knew they had "messed up" and should have washed their hands between cares and before leaving the resident's room. The DNS agreed with the CNA's that hand washing should have occurred more often throughout the above observation and absolutely before the CNA's left the resident's room and started caring for another resident.</p>	F 441			

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F 441	Continued From page 47 2. On 10/10/13 at 2:30 PM, during the environmental tour in the Soiled Linen Closet, located on Cape Hatteras, a bag of soiled linen was observed to be on the floor rather than in the container bin. The Director of Maintenance was present and stated the bag of soiled linen on the floor should be in the container bin and not on the floor. On 10/10/13 at 8:00 PM, the Administrator was informed of the above potential infection concerns. No further documentation was provided.	F 441		
F 456 SS=E	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to maintain patient care equipment in a safe operating condition. This was true for any resident who used the therapy gym equipment, a shower chair in the shower room located on the hall near the kitchen, and lift equipment located on Cape Elizabeth and Cape Hatteras. This had the potential for skin tears for residents with fragile skin who used the cracked and split equipment. Findings included: On 10/10/13 at 3:00 PM, during the environmental tour, the following equipment was found to contain multiple cracks, splits and open	F 456	F456 Resident Specific No residents were affected. Other Residents All residents that use the Therapy Gym table, shower chair, mechanical lifts on Cape Hatteras or Cape Elizabeth or the Sit to Stand on Cape Elizabeth have the potential to be affected. Facility Systems Therapy Gym table mat will be repaired or replaced. Shower chair cushion will be repaired or replaced. Mechanical lift hangar covers will be repaired or replaced. Sit to Stand shin guard will be repaired or replaced. Wheelchair arm rest will be replaced. Monitoring An audit will be performed by the Administrator/Designee weekly X4 weeks then every other week X4 weeks then monthly X3 months of all the mechanical lifts and shower chairs in the facility to ensure they are safe for resident use.	12/11/13

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F 456	Continued From page 48 areas: 1. The Therapy Gym contained a table mat which was observed to have multiple splits, cracks and open areas along the sides and corners revealing the foam cushion beneath the plastic. There was also a wheelchair arm rest which contained splits and cracks in the plastic. 2. The shower chair in the shower room near the kitchen was observed to have multiple splits and cracks in the plastic cushion seat. One split was approximately 1-1/2" in length which was sticking up from the seat, revealing a yellow foam cushion under the plastic seat. 3. Two mechanical lifts (an assistive device used to lift and transfer residents) contained suspender hanger covers which were split and cracked exposing the aluminum hangers on Cape Hatteras and on Cape Elizabeth in the Lift Storage Closets. In addition, the Pro Lift Sit to Stand, located on Cape Elizabeth, contained a shin guard which was cracked. The Director of Maintenance was present during the environmental tour and agreed the mat and the wheelchair arm rest in the Therapy Gym were cracked and open and looked bad. He also stated the shower chair seat should be replaced. On 10/10/13 at 8:00 PM, the Administrator was informed of the above environmental concerns. No further information was provided.	F 456		
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive	F 463	F463 Resident Specific No residents were affected.	12/11/13

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F 463	Continued From page 49 resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility did not ensure a call system was available in all toilet and bathing facilities. This was true for 1 of 2 restrooms in the reception area and had the potential to impact any resident who used the women's bathroom by the main entrance to the facility. The deficient practice had the potential to cause more than minimal harm if residents and/or staff assisting residents to toilet could not alert others in the event of an emergency. Findings included: On 10/8/13 at 4:00 PM it was noted that the Women's restroom by the main entrance did not have a call light. Both men and women were observed on 10/9/13 and 10/10/13 to sit on the couch, by the entrance door On 10/11/13 at 10:45 a.m. the Administrator and DNS were informed of this concern. The facility offered no further information.	F 463	F463 continued... Other Residents All female residents have the potential to be affected. Facility Systems A call light was installed in the women's restroom in the reception area by the main entrance to the facility.	
F 498 SS=D	483.75(f) NURSE AIDE DEMONSTRATE COMPETENCY/CARE NEEDS The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.	F 498	F498 Resident Specific 2 of 13 sampled residents (#s 1 & 10) were affected. Other Residents All residents have the potential to be affected.	12/11/13

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F 498	<p>Continued From page 50</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility did not ensure that certified nurse aides (CNAs) were trained to implement resident care plans. This was true for 2 of 13 sampled residents (#s 1 & 10) and had the potential for residents to be harmed if proper transfers or interventions for behaviors were not performed. Findings included:</p> <p>1. Resident #1 was admitted to the facility on 11/29/10 with diagnoses that included Alzheimer's disease, dementia with behavioral disturbance, obstructive sleep apnea and insomnia.</p> <p>Resident #1's 7/29/13 annual MDS Assessment documented behaviors of hitting, kicking, and grabbing.</p> <p>The resident's 10/1/13 Physician Order Report documented he was to have "1:1 (one to one) staffing 16 hr [hours per] day...Lack of safety awareness..."</p> <p>Resident #1's 7/30/13 "Lack of Safety Awareness Requiring 1:1 Staffing" care plan included the following:</p> <ul style="list-style-type: none"> *1:1 staffing due to lack of safety awareness *If agitated/physically aggressiveensure his safety and safety of his peers *Walk with him side by side due to fall risk, ambulate when restless *Be within arms length when in dining room due to choke risk *Impulsively touches staff and peers *Will bump into objects without any safety awareness and is prone to skin tears and bruising 	F 498	<p>F498 continued...</p> <p>Facility Systems In-service provided to all staff regarding their responsibility to read and understand the care plans of each of the residents to ensure proper care and safety of all residents; 1:1 staff responsibilities.</p> <p>Monitoring An audit will be conducted by the DNS/Designee 3 times a week X2 weeks then weekly X2 weeks then every other week X4 weeks then monthly X3 months of random shift floor staff providing 1:1 care to ensure they understand how to care for the 1:1 resident, why the resident is 1:1, location of resident's 1:1 care plan and where to find information on new resident that is 1:1 when care plan is not yet available.</p>

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

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/11/2013
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCATELLO, ID 83201		
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F 498	<p>Continued From page 51</p> <p>During observations on 10/8/13 Resident #1 was observed to be in his room with CNA #19 within arm's length of the resident. The surveyor asked CNA #19 why the resident required 1:1 supervision. CNA #19 stated she did not know why he required 1:1 supervision but she could ask.</p> <p>2. Resident # 10 was admitted to the facility on 9/24/13 with diagnoses that included a middle cerebral artery stroke.</p> <p>The resident's 10/4/13 Potential to Fall Care Plan documented the resident's fall risk was exhibited by poor coordination, history of falling and an unsteady gait. The interventions included staff were to provide more support on the resident's right side due to right sided weakness.</p> <p>On 10/9/13, at 4:00 p.m., Resident #10 was observed to have a 1:1 staff member. The surveyor asked CNA #20 how s/he would know what type of transfer assistance was needed for a resident who newly admitted to the facility. CNA #20 stated if the resident's family member was present s/he would ask the family member. CNA then stated if a family member was not present s/he would ask the nurse.</p> <p>On 10/9/13 at approximately 4:15 p.m. the CNA Staff Coordinator (SC) was asked how CNA's were informed of care for a resident who was just admitted to the facility. The SC stated CNA's are trained to look for the initial paperwork or care plan for new admits prior to working with the new resident. The SC stated for new admits all 1:1's have a binder in the room with an initial care plan. The SC stated she would "Stir away" from asking</p>	F 498		

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F 498	Continued From page 52 a family member.	F 498			
F 514 SS=D	483.75(I)(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 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. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to maintain clinical records on each resident in accordance with accepted professional standards and practices to ensure records were complete and accurate. This was true for 2 of 13 (#'s 10 & 14) sampled residents and 2 random residents (#'s 16 & 17). This deficient practice increased the risk for medical decisions to be based on incomplete or inaccurate information and increased the risk for complications due to inappropriate care or interventions. Findings included: 1. Resident #10's medical record included Progress Notes regarding Resident #17's 10/8/13 physician visit regarding surgical intervention for a	F 514 F514	Resident Specific 2 of 13 sampled residents (#s 10 & 14) and 2 random residents (16 & 17) were affected. Other Residents All residents have the potential to be affected. Facility Systems Residents #16 & #17 documentation was removed from resident #10's chart and placed in the appropriate chart. In-service will be provided to medical records and licensed nursing staff regarding placement of documentation in proper resident's chart. In-service provided to medical records staff regarding closing of charts in a timely manner; and 1) completeness, 2) accuracy, 3) readily accessible and 4) systematically organization of closed charts. Monitoring An audit will be conducted by the Administrator/Designee weekly X4 weeks then every other week X4 weeks then monthly X3 months to ensure closed charts are completed in a timely manner.	12/11/13	

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F 514	Continued From page 53 neurogenic bladder. 2. Resident #10's medical record included Resident #16's "Physician Order Flow Sheet" for 8/1/13. 3. Resident #14 was admitted to the facility on 8/12/11, re-admitted on 9/26/12, and passed away in the facility on 8/24/13. Resident #14's death certificate documented the cause of death as, "natural causes." On 10/9/13 at 6:30 PM, the surveyors asked for Resident #14's record to be made available the morning of 10/10/13 for closed record review. On 10/10/13 at approximately 9:00 AM the facility brought the surveyors a maroon plastic medical chart. The chart contained some of Resident #14's medical record organized and secured by a 3-ring binder feature. However, the record also contained approximately 2 inches of loose papers, ajar at a number of different angles, not secured, and in no discernable order. Even though the resident had passed away 50 days prior, the information in the chart did not include any information prior to 9/24/12, and only partial information from the period of time between 9/24/12 and the resident's death 11 months later. On 10/10/13 at 7:35 PM, the surveyor asked the facility Medical Records Director (MRD) for Resident #14's complete record. The MRD stated the complete record was not readily available, as the remainder of the record was in 2 boxes in the medical records office. The MRD was asked why the record was not complete, organized, and considered a closed record so long after the resident's death. The MRD stated she thought it had been closed until the surveyors asked for the	F 514		
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F 514	Continued From page 54 chart. Then she realized it had, "just been thrown in boxes." The surveyor then accompanied the MRD to the medical records office in the basement of the facility. The surveyor requested to see nurse's notes from September and October 2012. It took the MRD several minutes to locate the first box with records for Resident #14. The box was one which had originally held printer paper, and was approximately half full of loose, disorganized medical records for Resident #14. After rifling through the box for several minutes, the MRD stated, "Those notes are not in here. Let me see if I can find another box." After looking through the office for a few minutes, the MRD found another similar box with loose, disorganized records for Resident #14. With the surveyor searching through one box, and the MRD searching for another, the desired records were found after approximately half an hour.	F 514			
F 518 SS=E	483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility did not ensure staff were	F 518	F518 Resident Specific No residents were affected. Other Residents All residents have the potential to be affected. Facility Systems In-service will be provided to all staff regarding emergency procedures; Maintenance Director will be in-serviced regarding protocol for silencing fire alarms.	12/11/13	

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F 518	<p>Continued From page 55</p> <p>trained on procedures when responding to emergencies. This was true for 2 out of 2 staff members observed during a Fire Alarm. This deficient practice had the potential for harm should an emergency arise and staff do not know how to respond. Findings included:</p> <p>On 10/8/13 at 10:00 AM, the Fire Alarm on Cape Hatteras sounded and LN #1 called a Code Red over the intercom for the Boardwalk Dining Room area. Double doors were locked, resident doors were closed and staff responded with fire extinguishers. Confusion was noted by the staff as the Fire Alarm sounded on Cape Hatteras and not the Boardwalk Dining Room area. A few minutes passed before LN #1 realized he had called the Code Red to the wrong area and recalled the Code Red to the Cape Hatteras area. LN #1 neglected to cancel the Code Red to the Boardwalk Dining Room area.</p> <p>On 10/8/13 at 10:18 AM, the Administrator stated the fine cement dust, caused from the floor construction, activated the Fire Alarm.</p> <p>On 10/8/13 at 11:25 AM, the Director of Maintenance (DM) stated he readjusted the Fire Alarm since it was a false alarm. He stated he tried to call the Fire Department but they had already left the station.</p> <p>On 10/8/13 at 11:20 AM, LN #1 stated he announced the Code Red to the wrong area due to reading the Deep Room Cleaning Schedule which was posted beside the Fire Alarm Annunciator. He stated the Safe Haven Hospital and Care Fire Zone Listing was just below the Fire Alarm Annunciator. He stated he had removed the Deep Room Cleaning Schedule so</p>	F 518	<p>F518 continued...</p> <p>Monitoring An audit will be conducted by the Administrator/Designee weekly X4 weeks then every other week X4 weeks then monthly X3 months to ensure staff are knowledgeable of procedures for responding to emergencies.</p>	

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F 518	Continued From page 56 this misunderstanding will not happen again. No further information was provided.	F 518			

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C 000	16.03.02 INITIAL COMMENTS The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2. The following deficiencies were cited during the State licensure and complaint investigation survey that was conducted at your facility October 7-11, 2013. The surveyors conducting the survey were: Sherri Case, LSW, QMRP, Team Coordinator Nina Sanderson, LSW Amy Jensen, RN Becky Thomas, RN Survey Definitions: LN - Licensed Nurse	C 000		
C 121	02.100,03,c,v Encouraged/Assisted to Exercise Rights v. is encouraged and assisted, throughout his period of stay, to exercise his rights as a patient/resident and as a citizen, and to this end may voice grievances and recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal; This Rule is not met as evidenced by: Please refer to F166 as it relates to the facility resolving grievances.	C 121	C121 Please refer to the response to F166.	12/11/13

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JAN 31 2014
FACILITY STANDARDS

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



TITLE

ADMINISTRATOR

(X6) DATE

1/29/14

Bureau of Facility Standards

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C 155	Continued From page 1	C 155		
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 refer to F157 as it relates to notification of family.	C-155	C155 Please refer to response to F157.	12/11/13
C 176	02.105,01 Personnel Policies 105. PERSONNEL. 01. Personnel Policies. Personnel policies shall be developed and implemented and shall include: This Rule is not met as evidenced by: Please refer to F226 as it relates to policies on training all staff related to abuse.	C 176	C176 Please refer to response to F226.	12/11/13
C 252	02.106,07 MAINTENANCE OF EQUIPMENT 07. Maintenance of Equipment. The facility shall establish routine test, check and maintenance procedures for all equipment. This Rule is not met as evidenced by: Please refer to F-456 as it relates to maintenance of patient care equipment.	C 252	C252 Please refer to response to F456.	12/11/13
C 311	02.107,07 FOOD PREPARATION AND SERVICE 07. Food Preparation and Service. Foods shall be prepared by methods	C 311	C311 Please refer to response to F364.	12/11/13

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C 311	Continued From page 2 that conserve nutritive value, flavor and appearance, and shall be attractively served at proper temperatures. This Rule is not met as evidenced by: Please see F 364 as it pertains to food palatability.	C 311		
C 325	02.107,08 FOOD SANITATION 08. Food Sanitation. The acquisition, preparation, storage, and serving of all food and drink in a facility shall comply with Idaho Department of Health and Welfare Rules, Title 02, Chapter 19, "Rules Governing Food Sanitation Standards for Food Establishments (UNICODE)." This Rule is not met as evidenced by: Please see F 371 regarding food sanitation.	C 325	C325 Please refer to response for F371.	12/11/13
C 342	02.108,04,b,ii Toxics Stored Under Lock and Key ii. All toxic chemicals shall be properly labeled and stored under lock and key. This Rule is not met as evidenced by: Please refer to F-323 as it refers to locked storage of chemicals.	C 342	C342 Please refer to response to F323.	12/11/13
C 362	02.108,07,a Interior Surfaces Kept Clean & Sanitary a. Floors, walls, ceilings, and other interior surfaces, equipment and furnishing shall be kept clean, and shall be cleaned in a sanitary manner. This Rule is not met as evidenced by:	C 362	C362 Please refer to response to F253.	12/11/13

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C 362	Continued From page 3 Please refer to F-253 as it relates to a clean and sanitary environment.	C 362		
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. This Rule is not met as evidenced by: Refer to F463 as it relates to call system in bathrooms.	C 393	C393 Please refer to response to F463.	12/11/13
C 412	02.120.05,l Cold Water Drinking Fountain Requirements l. A drinking fountain connected to cold running water and which is accessible to both wheelchair and nonwheelchair patients/residents shall be located in each nursing or staff unit. This Rule is not met as evidenced by: Based on observation and staff interview, it was determined that the facility did not ensure that each nursing unit was equipped with a functioning water fountain. This was true for 3 of 3 nursing	C 412	C412 Specific Residents No specific residents were affected. Other Residents There were no residents affected. The facility requests a waiver for this year as we have received in the past for the following reasons. There were no residents affected by this citation do to our compliance with an annual waiver that requires us to provide water dispensers in the dining rooms, water pitchers on each nursing cart (2 per hall) and water is passed 2-3 times daily.	12/11/13

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C 412 Continued From page 4
units (Cape Hatteras, Cape Elizabeth, and Cape May) inspected. Findings include:

During the initial tour of the building it was observed that 3 of 3 nursing units, Cape Hatteras, Cape Elizabeth, and Cape May did not have drinking fountains.

C 412 C412 continued...
Monitoring

Audits are performed on a regular basis to ensure the residents are hydrated properly and the current policy is adequate.

C 445 02.120,13,c Hot Water Temps 105-120 Degrees F

c. The temperature of hot water at plumbing fixtures used by patients/residents shall be between one hundred five degrees (105F) and one hundred twenty degrees (120F) Fahrenheit.
This Rule is not met as evidenced by:
Based on observation and staff interview, it was determined the facility failed to ensure comfortable water temperatures. This was true for any resident who used Shower Rooms #1, #3, and #4. Findings included:

On 10/10/13 at 4:40 PM, during the Environmental Tour, the temperatures in the following shower rooms were found to be under the required temperature of 105 - 120 degrees Fahrenheit (F):
*Shower Room #1 - 97.1 degrees F
*Shower Room #3 - 101 degrees F
*Shower Room #4 - 96.6 degrees F

The Director of Maintenance (DM) was present and stated he had turned down the hot water thermostat approximately a week ago and must have turned it down too low. The DM stated he would turn up the thermostat and make sure the above shower rooms were at the required

C 445 C445

Resident Specific
No specific residents were affected.

Other Residents
Any resident that uses shower rooms #1, 3 or 4 have the potential to be affected.

Facility Systems
Maintenance Director to turn up hot water thermostat.

Monitoring
A random audit will be performed by the Maintenance Director weekly X4 weeks then every other week X 4 weeks then monthly X3 months to ensure the hot water temperatures in shower rooms 1, 3 and 4 are within required limits.

12/11/13

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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
C 445	Continued From page 5 temperature so it would be comfortable for the residents.	C 445		
C 644	02.150,01,a,i Handwashing Techniques a. Methods of maintaining sanitary conditions in the facility such as: i. Handwashing techniques. This Rule is not met as evidenced by: Please refer to F441 as it relates to prevention of infection via handwashing.	C 644	C644 Please refer to response to F441.	12/11/13
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 regarding resident input on care plans.	C 778	C778 Please refer to response to F279.	12/11/13
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: Please refer to F272 as it relates to side rail assessment (non-restraint).	C 779	C779 Please refer to response to F272.	12/11/13
C 782	02.200,03,a,iv Reviewed and Revised	C 782	C782 Please refer to response to F280.	12/11/13

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001620	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/11/2013
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NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO	STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCATELLO, ID 83201
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C 782	Continued From page 6 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: Please refer to F-280 as it refers to plan of care review and revision.	C 782		
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 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 ensuring residents receive necessary care and services.	C 784	C784 Please refer to response to F309.	12/11/13
C 804	02.200,04,g Recorded on Medication Record g. Each patient's/resident's medication is properly recorded on his individual medication record by the person administering the medication. The record shall include: This Rule is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to document medications were given after the resident had taken their medications. This was true for 1 out of 22 residents sampled (#22) for medication administration observation. Findings include: On 10/8/13 at 4:55 PM, LN #8 was observed, during a medication administration observation, to administer eight medications to random Resident	C 804	C804 Resident Specific 1 of 22 sampled residents was affected. Other Residents No other residents were affected. Facility Systems In-service will be provided to all licensed nurses to ensure proper documentation of medication administration.	12/11/13

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001620	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/11/2013
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NAME OF PROVIDER OR SUPPLIER
SAFE HAVEN CARE CENTER OF POCATELLO

STREET ADDRESS, CITY, STATE, ZIP CODE
**1200 HOSPITAL WAY
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) COMPLETE DATE
C 804	Continued From page 7 #22. However, after the medications were given, LN #8 did not sign the medication administration record (MAR). On 10/8/13 at 5:16 PM, LN #8 stated he had forgotten to sign the MAR. On 10/9/13 at 5:15 PM, the Administrator and DON were made aware of the failure to document medications had been given. No further information was provided.	C 804		
C 821	02.201,01,b Removal of Expired Meds b. Reviewing all medications in the facility for expiration dates and shall be responsible for the removal of discontinued or expired drugs from use as indicated at least every ninety (90) days. This Rule is not met as evidenced by: Please refer to F-431 as it refers to expired medications.	C 821	C821 Please refer to response to F431.	12/11/13
C 832	02.201,02,f Labeling of Medications/Containers f. All medications shall be labeled with the original prescription legend including the name and address of the pharmacy, patient's/resident's name, physician's name, prescription number, original date and refill date, dosage unit, number of dosage units, and instructions for use and drug name. (Exception: See Unit Dose System.) This Rule is not met as evidenced by: Please refer to F-431 as it relates to medication	C 832	C832 Please refer to response to F431.	12/11/13

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001620	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/11/2013
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NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO	STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCATELLO, ID 83201
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C 832	Continued From page 8 labels	C 832		



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

December 5, 2013

Steve Gannon, Administrator
Safe Haven Care Center of Pocatello
1200 Hospital Way
Pocatello, ID 83201-2708

Provider #: 135071

Dear Mr. Gannon:

On **October 11, 2013**, a Complaint Investigation survey was conducted at Safe Haven Care Center of Pocatello. Sherri Case, L.S.W., Q.M.R.P., Nina Sanderson, L.S.W., Amy Barkley, R.N. and Becky Thomas, R.N. conducted the complaint investigation. The complaint investigation was completed in conjunction with the facility's annual Recertification, State Licensure survey and two additional complaint investigations.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00005754

ALLEGATION #1:

The complainant expressed the following concerns:

1. A portable oxygen tank was not available for an identified resident (A) who was oxygen dependent, so the resident was unable to leave his room.
2. Sanitary wipes not available for staff to provide incontinent care to residents.
3. Nursing staff's delayed response to assess a second identified resident (B), who experienced an acute change in his condition after a fall.

FINDINGS:

1. During observations throughout the survey, residents who needed them, including resident A,

were observed to have portable oxygen tanks. Additionally, five Certified Nurse Aides (CNAs) were interviewed and stated portable oxygen tanks were always available. A group interview was held with thirteen residents in attendance. The residents did not express concerns regarding the availability of oxygen. Grievance files reviewed for the previous six months did not identify concerns regarding the availability of portable oxygen.

2. During observations throughout the survey, the CNAs were observed to have sanitary wipes available when providing incontinence care. Additionally, five CNAs and one licensed nurse stated there had not been a problem obtaining sanitary wipes when needed. A group interview was held with thirteen residents in attendance. The residents did not express concerns regarding the availability of sanitary wipes. Grievance files reviewed for the previous six months did not identify concerns regarding the availability of sanitary wipes.
3. Medical records were reviewed for ten residents including the identified resident B. Resident B's medical record documented that the resident was assessed in a timely manner after he experienced an acute change in his condition from a fall. The facility; however, was sited at F309 during the survey process for failure to assess a venous stasis ulcer on resident C until after a family member requested the ulcer be assessed.

CONCLUSIONS:

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

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

If you have questions 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,



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



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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FAX 208-364-1888

November 21, 2013

Steve Gannon, Administrator
Safe Haven Care Center of Pocatello
1200 Hospital Way
Pocatello, ID 83201-2708

Provider #: 135071

Dear Mr. Gannon:

On **October 11, 2013**, a Complaint Investigation survey was conducted at Safe Haven Care Center Of Pocatello. Sherri Case, L.S.W., Q.M.R.P., Nina Sanderson, L.S.W., Amy Barkley, R.N. and Becky Thomas, R.N. conducted the complaint investigation.

During the Recertification and State Licensure survey between October 7 and October 11, 2013, surveyors were in the facility daily, checking for ambient noise levels. Several residents, including the identified resident, were interviewed regarding noise levels. The Ombudsman was contacted. The record of the identified resident was reviewed. The facility's Administrator, owner and Director of Nursing (DoN) were interviewed.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00006004

ALLEGATION #1:

The complaint stated an identified resident, as well as several unidentified residents, were subjected to loud noise levels for a period of five days between April 5 and April 10, 2013, during which some remodeling was being done at the facility.

FINDINGS:

At the time of the survey, remodeling within the facility had been completed. There was some construction being done on the exterior of the building, but the sound from that construction

Steve Gannon, Administrator
November 21, 2013
Page 2 of 2

could not be heard inside the facility.

Residents were interviewed, both individually and as a group. The residents did not report any concerns with noise levels in the facility, neither currently nor at the time the complaint was made.

The identified resident's record indicated the resident's hearing had been tested after the date of the complaint, with no impairment noted. The facility had offered the identified resident ear protection, which the identified resident declined.

The Ombudsman was aware of the situation, and the identified resident in the complaint. The Ombudsman investigated the matter at the time the complaint was made but was unable to substantiate that noise levels were ever at unacceptable levels.

The facility's Administrator and the facility's owner stated they were aware of the concern for the identified resident at the time it occurred. The facility's owner stated decibel levels had been checked at the time the complaint was made known, while remodeling was still in process, with no damaging levels noted. The facility's owner stated the identified resident was offered ear protection, and a hearing test was completed after the concern was brought to the facility's attention with no deficits noted.

The identified resident reported awareness of all of the above-mentioned items, including the decibel level testing done by the facility's owner, and the outcome of the hearing tests. Nevertheless, the identified resident felt the facility's owner had misrepresented the decibel readings at that time and that the results of the hearing test were inaccurate; however, there was no evidence of this. The identified resident stated that since the remodel had been completed on April 10, 2013, there had been no further issues with noise in the facility.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

As none of the complaint's allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,



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

LKK/dmj



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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November 21, 2013

Steve Gannon, Administrator
Safe Haven Care Center of Pocatello
1200 Hospital Way
Pocatello, ID 83201-2708

Provider #: 135071

Dear Mr. Gannon:

On **October 11, 2013**, a Complaint Investigation survey was conducted at Safe Haven Care Center of Pocatello. Sherri Case, L.S.W., Q.M.R.P., Nina Sanderson, L.S.W., Amy Barkley, R.N. and Becky Thomas, R.N. conducted the complaint investigation.

As a part of this investigation, facility grievances were reviewed, the identified resident was interviewed, other residents were interviewed both individually and as a group and the facility's administrator was interviewed.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00006013

ALLEGATION #1:

The complainant stated an identified resident was charged for haircuts not received and purchases never made.

FINDINGS:

The facility had a grievance on file for the above allegation. Though the facility's documentation indicated the resident had received the haircuts, the identified resident's account was reimbursed the amount of the charges made as the resident continued to express concern on this matter.

Steve Gannon, Administrator
November 21, 2013
Page 2 of 3

The identified resident stated the issue had been resolved at the time and had not been an issue since.

Other residents interviewed, stated they had no concerns with missing funds or charges made against their accounts inappropriately.

The facility's administrator stated the charges were accurate but due to the continued concern, the identified resident was reimbursed.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The complainant stated an identified resident had not received quarterly trust account statements for 2011 or 2012, but began receiving the statements for 2013.

FINDINGS:

The identified resident, other facility's residents and the facility's administrator were interviewed about residents' trust accounts.

The identified resident stated trust account statements were not provided in 2011 or 2012. Only after requested from the facility, did the resident begin to receive statements in 2013. The identified resident stated the trust account statements had been received regularly over the past year.

Other residents were interviewed individually and as a group. Neither the individual residents nor the resident group had concerns about receiving statements from the facility.

The facility's administrator reported statements on resident's trust accounts came from an out-of-state accounting office, and were typically delivered to residents or the resident's representatives by mail. The administrator stated the identified resident had begun to express that the statements were not coming in the mail approximately one year ago. The administrator stated the facility checked with the company generating the statements, and was assured that the statements were being sent. The facility arranged for the identified resident to continue receiving a statement in the mail and additionally, the facility began to supply a hand-delivered statement.

In addition, the time for which the complaint was made preceded the survey look-back period. Currently, there are no issues related to residents' trust account statements.

Steve Gannon, Administrator
November 21, 2013
Page 3 of 3

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

As none of the complaint's allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

A handwritten signature in black ink that reads "Lorene Kayser". The signature is written in a cursive, somewhat stylized font.

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

LKK/dmj