



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
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CERTIFIED MAIL: 7012 3050 0001 2125 5983

November 19, 2014

David L. Green, Administrator
Owyhee Health & Rehabilitation Center
108 West Owyhee, PO Box A
Homedale, ID 83628-2040

FILE COPY

Provider #: 135087

Dear Mr. Green:

On **November 4, 2014**, a Complaint Investigation survey was conducted at Owyhee Health & Rehabilitation Center by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be an isolated deficiency that constitutes actual harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies and a similar State Form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3.) **Please provide ONLY ONE completion date for each federal and state tag in column (X5) Completion Date** to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.

After each deficiency has been answered and dated, the administrator should sign both the Form CMS-2567 and State Form, Statement of Deficiencies and Plan of Correction in the spaces provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **December 2, 2014**. Failure to submit an acceptable PoC by **December 2, 2014**, may result in the imposition of civil monetary penalties by **December 22, 2014**.

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

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

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

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

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

This agency is required to notify CMS Region X of the results of this survey. We are recommending that CMS impose the following remedy:

Denial of payment for new admissions effective as soon as notice requirements can be met. [42 CFR §488.417(a)]

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **May 4, 2015**, if substantial compliance is not achieved by that time.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare &

David L. Green, Administrator
November 19, 2014
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Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact Lorene Kayser, L.S.W., Q.I.D.P. or David Scott, R.N., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, Fax #: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance.

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

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

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

- BFS Letters (06/30/11)

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

This request must be received by **December 2, 2014**. If your request for informal dispute resolution is received after **December 2, 2014**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,



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

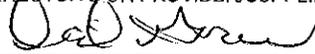
LKK/dmj
Enclosures

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

PRINTED: 11/18/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135087	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/04/2014
NAME OF PROVIDER OR SUPPLIER OWYHEE HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 108 WEST OWYHEE HOMEDALE, ID 83628	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the complaint survey of your facility.</p> <p>The surveyors conducting the survey were: Arnold Rosling, RN, BSN, QMRP Linda Hukill-Neil, RN</p> <p>The survey team entered the facility on November 3, 2014 at 7:30 a.m., and exited the facility on November 4, 2014.</p> <p>Survey Definitions: ADL = Activities of Daily Living CNA = Certified Nurse Aide DNS/DON = Director Nursing Services/Director of Nursing LN = Licensed Nurse MDS = Minimum Data Set assessment R/T = Related To cm = Centimeter LLE = Left Lower Extremity RLE = Right Lower Extremity ABD = Name of a Large soft padded dressing.</p>	F 000	<p>"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Qwyhee Health and Rehab does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."</p> <p>RECEIVED NOV 13 2014 FACILITY COMPLAINTS</p>	
F 309 SS=G	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 309		

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



TITLE

Administrator

(X6) DATE

12-1-14

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

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F 309	<p>Continued From page 1</p> <p>Based on staff interview, medical record review and incident review, it was determined the facility failed to ensure that 1 of 10 (#5) sampled residents received care according to their care plan. As a result Resident #5 was harmed when staff failed to follow the resident's care plan to transfer the resident with a mechanical lift. This resulted in a fractured femur and eventual above the knee amputation. Findings include:</p> <p>Resident #5 was admitted to the facility on 8/11/11 and readmitted on 6/26/14 with diagnoses of senile dementia with depressive features and osteoporosis.</p> <p>The 7/2/14 significant change MDS assessment documented the resident:</p> <ul style="list-style-type: none"> - had short and long term memory problems, - was total assist with ADL cares, - required mechanical lift for transfers. <p>On 6/6/14 the resident was found to have an injury to her left leg. On 6/6/14 at 8:10 p.m. the director of nursing documented a progress note of, "Resident was discharged to hospital this afternoon after it was reported that her L[eft] leg did not 'look right', [Physician name] notified and x-rays obtained which showed a L[eft] femur fracture."</p> <p>The facility's investigation report documented that on 6/6/14 at 9:15 a.m., "Charge Nurse [name] was coming down the hallway, meet [sic] her in hallway she stated that [resident name] leg does not appear normal something wrong with it. I went right to [resident name] room to assess her left leg. Left leg is swollen and disformed, [charge nurse name] gave her extra pain meds and I called Dr [name] getting orders for x-rays."</p>	F 309	<p>F 309</p> <p>Corrective Actions: Education was provided for all nursing staff on the importance using mechanical lifts when on the care plan 11/7/14</p> <p>Identification of others affected and corrective actions: All residents that use a mechanical lifts could have been affected.</p> <p>Measures to ensure that the deficient practice does not happen again: The facility's annual education calendar will be updated to reflect the importance of using mechanical lifts when on the care plan on a quarterly bases by 11/25/14.</p> <p>Monitor corrective actions: DON or designee will audit appropriate mechanical lift use 2 X week for 8 weeks on random halls. The audit results will be brought to QA monthly. Audits to begin 11/26/14</p> <p>Corrective Actions will be completed</p>	12/2/14	

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F 309	Continued From page 2 The incident report documented the resident had a shower on 6/6/14 at 6:30 a.m. and the resident had a fall assessment of 16 [Note: date of assessment not documented.], which indicated she was at high risk for falls. The conclusion of the investigation determined that two CNAs transferred the resident to a shower chair using a two person stand and pivot transfer, rather than a mechanical lift as care planned. The pivot transfer resulted in a spiral fracture of the resident's left femur. Resident #5's care plan, dated 4/23/14, [Note: This was the care plan in place when the incident occurred, not the current care plan.] documented a "Focus" of "ADL Self Care Performance Deficit, cognitive loss and severely impaired mobility Alzheimer's." One of the interventions was, "Transfers: Requires Hoyer lift transfers with staff assist of 2." On 11/4/14 at 3:30 p.m. the DON stated the incident was investigated as an injury of unknown origin. The bath aide and another CNA stated they performed an improper transfer of the resident. Both employees were terminated because they failed to follow the resident's care plan. The resident returned to the facility on 6/10/14. The resident's medical record documented the resident had a knee immobilizer in place to support the fractured area. The resident's legs were small and the facility had difficulty keeping the fractured area immobilized. Some of the nursing documentation was:	F 309			

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F 309	<p>Continued From page 3</p> <p>On 6/10/14 at 5:37 p.m., an LN documented, "... re-admitted from [Hospital name] at noon... Tylenol given for fever upon arrival. Resident alert and rocking in her normal type of movement. Appears that she may have pain related to leg fracture... Fracture to left femur near knee. No surgery [due to] [name] is not a candidate. Knee immobilizer in place. Superficial blister to back of left thigh with red irritation from brace noted. Sheepskin to top to keep from rubbing skin, staff to monitor [each] shift. Staff instructed to change position every 2 hours and support left leg carefully with each movement. Can be up in chair with proper support of leg..."</p> <p>On 6/11/14 at 10:02 p.m., an LN documented, "...Awake a lot of the day. Bed in low position fall mat on floor. A little restless but this is her norm. Routine pain meds have kept her calm and no non-verbal indicators such as furrowed brow, excessive restlessness. Was up in wheelchair at supper time. Hoyer lift used for transfers. After, tilted back and at nurses station so could be observed... Resident kept putting her leg over edge of the wheelchair. Replaced at least 7 times in a short period of time. Was put to bed and positioned on her side. Knee immobilizer in place with sheepskin lining... Position change and leg elevated when in bed but does not stay when she is restless. Did not have leg over edge of bed today..."</p> <p>On 6/13/14 at 3:21 a.m., an LN documented, "...Knee immobilizer in place to L leg... Noted bruise to L[eft] Labia. The top of the brace has rubbed when up in wheelchair causing her skin to bruise. Adjusted immobilizer to keep away from the labia when her body is in a bent position..."</p>	F 309			

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F 309	<p>Continued From page 4</p> <p>On 6/17/14 the physical therapist documented a late entry of, "Provided CNA training with pt [patient] on safety with Hoyer lift transfer and management of RLE [right lower extremity] during transfer. Provided instruction on bed mobility with management of RLE, positioning within Geri Chair with use of tilt component and LE positioning to maintain R knee in knee immobilizer with knee extension and good support. Pt continues to have lab [sic] buddy for positioning purposes as well..." [Note: the resident's LLE [left lower extremity] had the fracture and immobilizer not the RLE.]</p> <p>On 6/20/14 at 5:03 p.m., and LN documented, "...L leg immobilizer in place. Brace released and skin checked for pressure areas. Superficial peeling skin on the outer aspect of the L knee and lotion applied. Cleansed right groin superficial split in the skin. Area cleaned and barrier cream applied. Cont[inues] to have internal rotation of her L foot. Positioned with pillows carefully. Continue to monitor labia for bruising."</p> <p>On 6/21/14 at 3:06 p.m., an LN documented, "...During weekly SAR [skin at risk] last evening the following skin issue was noted to left lateral knee? [sic] Lateral L. knee has raised area which appears to be fluid filled with palpation. Warm to touch. Near bottom is a 0.5 whitish area with dark center? This afternoon it appears that a ? skin plug ? came out of lateral side of knee and created a 0.5 cm opening. A copious amount of serosanguinous fluid came at first, then only a small amount occasionally as she moved her knee. As we were cleaning the area and apply an ABD pad, [name] was moving her leg and knee. When she bent her knee the outline of a bone under the skin was visible that is approximately 1</p>	F 309			

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F 309	Continued From page 5 cm above the opening..." On 6/22/14 at 4:21 a.m., an LN documented, "... Dressing changed to left knee. Copious amount of serosanguineous drainage noted to old dressing. 0.5 cm open area noted to lateral side of left knee with bone visible. No odor or warmth noted. Knee immobilizer carefully re-applied. Routine pain medication given and is helpful. No moaning or facial grimacing noted..." On 6/22/14 at 9:04 a.m., the LN documented, "[Physician Name] notified regarding bone protruding out of Left lateral knee. Gave new order to send to [Hospital name]. The resident was admitted to the hospital and an above the left knee amputation was performed. The resident was readmitted to the facility on 6/26/14 for post-operative and long term care. The resident was harmed when two CNA staff failed to follow the resident care plan and performed a pivot transfer of the resident when she was care planned to be a mechanical lift. This inappropriate transfer resulted in a fractured left femur which eventually resulted in a left above the knee amputation.	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			

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F 323	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on clinical records, staff interviews, and observations, it was determined the facility failed to ensure 1 of 3 residents (#2) sampled for scratches, bruises, and skin tears were provided with interventions to prevent the reoccurrence of skin injuries. Resident #2 was harmed when she had repeated skin injuries, which had resulted from staff's inadequate care for left sided deficits. Findings included: Resident #2 was admitted to the facility on 5/27/14 with multiple diagnoses including Cardiovascular Accident (CVA) with left sided deficits, psychosis due to stroke, muscle weakness, and dysphagia. The resident's quarterly MDS assessment dated 7/31/14 documented: *BIMS score of 9-moderately impaired; *Functional limitation in range of motion-Impairment on upper and lower extremities-Impairment on one side; and *Skin Problems-Skin tears. Resident #2's October 2014 Care Plan documented: *Self care deficit in activities of daily living, related to a CVA with left sided deficit, initiated 5/27/14. Interventions initiated 5/27/14, included the need of 1 staff participation with transfers and bathing; and for staff to avoid scrubbing and to pat dry sensitive skin. *Potential for pressure ulcer development related to decreased mobility and left sided weakness initiated 5/27/14. Interventions initiated 5/27/14,	F 323	F323 Corrective Actions: Resident # 2 has heavy geri sleeves to protect upper extremities. Therapy has assessed resident for ½ lap top to w/c for increased left arm support. Lap top is now used while up in w/c. Identification of others affected and corrective actions: All residents with unilateral muscle weakness could have been affected. Measures to ensure that the deficient practice does not happen again: Facility will educated nursing staff on care plan preventions for skin impairment interventions by 11/18/14 Monitor corrective actions: DON or designee will audit skin I & A's monthly for 3 months for trends. The audit results will be brought to QA monthly. Audits to begin 11/26/14 Corrective Actions will be completed	12/2/14	

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F 323	<p>Continued From page 7</p> <p>included educate resident, family, and caregivers to causes of skin breakdown, transfer and positioning requirements, importance of taking care during ambulating and mobility, weekly head to toe skin checks, and notification of nurse during bath or daily care of new areas of skin breakdown.</p> <p>The facility provided Resident #2's Skin Impairment Care Plan that had been resolved on 8/4/14. The resident did not have a current Skin Impairment Care Plan, though there continued to be skin impairment issues. The Skin Impairment Care Plan documented: "...Resolved: Will reduce risk for impairment to skin integrity through the use of (Geri gloves and elbow pads) through the review date...Resolved date: 8/4/2014..."</p> <p>The resident's weekly skin checks documented: 10/1/14 - "...Skin tear on L forearm is closed. Cont[inue] to have irregular texture to the skin surface. Bruising on L arm is resolved. Geri gloves on arms for protection. Bruise on L shin is almost resolved..." 10/8/14 - "...irregular texture to the skin surface where old skin tear was on L forearm. Geri gloves on arms for protection. Bruise on L shin is almost resolved..." 10/22/14 - "Cont[inue] to have scattered keratotic areas on hands and arms. Geri gloves on arms for protection. Bruise on L [left] shin is resolved..." 10/28/14 - "...Skin is pale, warm and dry. Cont[inue] to have areas on hands and arms. Geri gloves on arms for protection..."</p> <p>Resident #2's Skin Occurrence Reports documented: 7/24/14 - Resident received a 1.5 cm skin tear on</p>	F 323		
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F 323	<p>Continued From page 8</p> <p>the L leg, after a CNA bumped her leg on a wheelchair.</p> <p>9/2/14 - Resident received a 1.5 cm bruise on her left shin, after a CNA had bumped the left shin with a walker.</p> <p>9/8/14 - Resident received a 3.5 cm (centimeter) by 4 cm skin tear and bruise, on the left forearm, after a CNA had taken her into the bathroom.</p> <p>On 11/4/14 at 11:05 AM, LN #1 was observed performing a skin inspection of Resident #2's arms and legs. The resident was lying on the bed and there were no noted bruises or skin tears. LN #1 stated, "No, she does not have geri gloves or elbow protectors on. The CNAs are the ones that would place them on."</p> <p>On 11/4/14 at 2:54 PM, the Administrator and DNS were informed of the outcome of the complaint investigation. No additional information was provided.</p>	F 323			

Bureau of Facility Standards

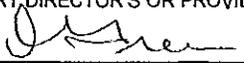
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001660	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/04/2014
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NAME OF PROVIDER OR SUPPLIER OWYHEE HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 108 WEST OWYHEE HOMEDALE, ID 83628
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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C 000	16.03.02 INITIAL COMMENTS The following deficiencies were cited during the complaint survey of your facility. The surveyors conducting the survey were: Arnold Rosling, RN, BSN, QMRP Linda Hukill-Neil, RN The survey team entered the facility on November 3, 2014 at 7:30 a.m., and exited the facility on November 4, 2014.	C 000		
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: Refer to F 309 as the facility failed to follow the care plan.	C 784	Refer to F309	
C 790	02.200,03,b,vi Protection from Injury/Accidents vi. Protection from accident or injury; This Rule is not met as evidenced by: Refer to F323 as it relates to protection from accidents or injuries.	C 790	Refer to F323	

RECEIVED
DEC 30 2014
FACILITY STANDARDS

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 12-30-14
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IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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

December 19, 2014

David L. Green, Administrator
Owyhee Health & Rehabilitation Center
PO Box A
Homedale, ID 83628-2040

FILE COPY

Dear Mr. Green:

On **November 4, 2014**, a Complaint Investigation survey was conducted at Owyhee Health & Rehabilitation Center. Linda Hukill-Neil, RN and Arnold Rosling, RN, QIDP, conducted the complaint investigation.

During the complaint investigation, the medical records of ten residents, including that of the identified resident, were reviewed. Facility incident and accident reports were reviewed, observations of meals and resident cares were conducted and facility staff were interviewed.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00006703

ALLEGATION #1:

The complainant stated that an identified resident had significant weight loss from February to July 2014.

FINDINGS:

The identified resident did have some weight loss. The resident had Parkinson's disease and had problems with dysphagia and swallowing. The facility identified the problem.

The April 6, 2014, Dietary - Quarterly Evaluation, documented the resident was on a regular diet and nutrition enhanced meals with one scoop of protein powder three times a day with meals. He was to receive a pureed texture diet. The resident also was receiving a house supplement with meals. The dietary evaluation documented the resident's weight on April 2, 2014 at 1:59 p.m. to be 114 pounds and

David Green, Administrator
December 19, 2014
Page 2 of 5

a height of 65 inches. The resident needed total assistance with eating. The evaluation narrative documented, "Resident weight has been trending down. Through communication with wife, house supplements were started... Weight loss is not desirable for resident. His skin remains fragile. He is full assist with meals. Average daily intakes 100% all meals. Fluids 2702 cc every day. MD notified of weight loss. Resident with diagnoses of end stage dementia. Unavoidable weight loss and failure to thrive. Continue to monitor weights and intakes."

The July 1, 2014 Dietary - Quarterly Evaluation documented the resident was on a regular diet and nutrition enhanced meals. He was to receive a pureed texture diet. The resident also was receiving a house supplement with meals. The dietary evaluation documented the resident's weight on June 30, 2014 at 1:59 p.m. to be 117.5 pounds and a height of 65 inches. The evaluation narrative documented, "Resident's weight stable x 6 months, 115 -119, current BMI (Base Metabolic Index) 19.6. Resident unable to make food preferences known. Average daily intakes 100%/100%/97%. Fluids 2225 cc every day. Continue to honor wife's preferences for resident. No new interventions at this time."

The resident did have some weight loss. The facility identified the weight loss, implemented interventions and the resident's weight stabilized.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The complainant indicated the resident was not turned while in bed per care plan.

FINDINGS:

The resident's medical record documented that he was turned and positioned every one and one half hours. The resident was on an air bed and the staff utilized pillows to aide in positioning for comfort. Skin issues were identified on the record. The resident had moisture issues with the gluteal cleft but staff used barrier creams and protection to prevent it from breaking down. The resident's wheelchair had a pressure reduction cushion in it to prevent the resident from skin breakdown.

Observations of other residents in the facility who were laid down after meals revealed they were not in bed longer than two hours and were up to their wheelchairs, no skin issues noted.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The complainant stated the resident's incontinent briefs were not changed.

FINDINGS:

The resident's medical record did not have any documentation the resident was not checked and changed when he was incontinent.

Observations of other residents revealed the staff do make rounds during their shifts to check, change and toilet residents.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

The complainant indicated that the resident was taken to breakfast in night clothes.

The complainant stated that the resident's hygiene needs were not met by staff (i.e., shaving, incontinent care, dressing, making bed).

FINDINGS:

The resident's medical record was reviewed and unannounced observations were completed at breakfast on November 3rd and 4th, 2014.

The resident's medical record did not document the resident was taken to breakfast in his night clothes.

Every resident who resided in the facility was observed eating breakfast or getting assistance with eating. Every one of the residents was dressed and groomed appropriately. The dining area, during the observations, showed a relaxed therapeutic environment and residents were observed to eat most all of their meals.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #5:

Complainant indicated there was insufficient staff to meet residents' needs.

FINDINGS:

The resident's medical record and staffing schedules for August, September, October and November 2014 were reviewed.

There were no indications in any of the reviews that there was not sufficient staff to care for the residents. The facility aide staffing consisted of three Certified Nurse Aides (CNA's) to provide direct care, one bath aide and a restorative CNA on the day shift. There were three CNAs on the evening shift and two CNAs on the night shift. This was in addition to licensed nurses on each shift. No care needs were identified and residents were well groomed. Random interviews with residents revealed there were no staffing concerns.

Not able to substantiate the allegation of insufficient staff.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #6:

The complainant stated the resident had significant bruising of unknown origin on the bilateral upper extremities.

FINDINGS:

Review of the resident's medical record and care plan and the incident reports was completed.

Bruising was noted on the resident's arms May 14, 2014. The resident's care plan was changed and documented, "Has potential for skin tears and bruising r/t (related to) fragile skin." There were ten interventions put in place to prevent recurrence. Some of the interventions were:

- Keep skin clean and dry. Use lotion on dry scaly skin.
- Needs padded wheelchair arms, padded side rails, and pressure relieving cushion while in chair.
- Needs pressure relieving mattress, pillows and siderail protection to protect skin while in bed.
- Needs geri sleeves for the arms.
- Needs nails kept short to reduce risk of scratching or injury from picking at skin. and
- Use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface.

David Green, Administrator
December 19, 2014
Page 5 of 5

The medical record did not reveal the resident had any further issues with excessive bruising after the care plan was implemented.

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 letters are somewhat stylized and slanted.

LORENE KAYSER, LSW, QIDP, Supervisor
Long Term Care

LK/lj



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
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FAX 208-364-1888

December 19, 2014

David Green, Administrator
Owyhee Health & Rehabilitation Center
PO Box A
Homedale, ID 83628-2040

FILE COPY

Provider #: 135087

Dear Mr. Green:

On **November 4, 2014**, a Complaint Investigation survey was conducted at Owyhee Health & Rehabilitation Center. Linda Hukill-Neil, RN, and Arnold Rosling, RN, QIDP, conducted the complaint investigation.

The complaint was investigated on November 3rd and 4th, 2014.

The following documentation was reviewed:

- Individual Resident medical records.
- Individual incident reports for the past six months.
- Staff schedules for August 2014, September 2014, October 2014 and November 2014.
- All residents with mechanical lifts were reviewed.

Interviews were conducted with:

- Three Certified Nurse Aides;
- Three Registered Nurses;
- Director of Nursing;
- Administrator; and
- Medical Records designee.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00006725

ALLEGATION #1:

The complainant stated there would be reported a minimum of 10 to 11 new skin issues, which included bruises and skin tears on residents that had occurred daily and/or weekly to the licensed nurses. The licensed nurses would get upset when the Certified Nurse Aides would report concerns, because the nurses did not want to fill out incident reports.

The complainant identified concerns related to the following residents:

Resident A has skin tears and bruises from the knuckles to the shoulders.

Resident D is a two person extensive assist with transfers and was being transferred by one person. The identified resident was found to have a skin tear on the top of the hand and lower leg.

Resident B was being rushed in a wheelchair to the bathroom by a Certified Nurse Aide and the resident's flaccid arm struck the bathroom door hinges. The resident received a skin tear on her arm.

FINDINGS:

1. Resident A's medical record and the facility's incident and accident reports were reviewed, staff interviews conducted, and observations completed for the allegations of skin tears and bruises from the knuckles to the shoulders. The resident's diagnoses included dementia with behavioral disturbances and Parkinson's.

The resident had eight reports of skin occurrences, which included bruises, scratches, and skin tears from June 18, 2014 to October 7, 2014. All eight skin occurrence reports, after thorough investigations by the facility for each occurrence, revealed the bruises, scratches, and skin tears were caused by the resident. There were no environmental hazards or staff involvement to indicate these circumstances could have been prevented. Staff interviews did not reveal that any different measures could have been implemented to have prevented the skin occurrences.

Resident A's Care Plan, Medication Administration Record, and Treatment Administration Record did have interventions in place. The resident's record and the observations on November 3rd and 4th, 2014 reflected the interventions were being completed. The licensed nurse does a head to toe skin check twice a day for this resident.

Resident A was observed on November 4, 2014, while a licensed nurse performed a skin inspection from the shoulders to the hands and there was no noted skin tears, bruises, or scratches.

Resident A's investigation did not show the facility had a deficit practice and so the complaint for this resident is unsubstantiated.

2. Resident D's medical record and the facility's June through current month incident and accident reports were reviewed, staff interviews, and observations completed for the allegations of the resident being transferred by one person when she was a two person assist, and skin tears on the top of the hand and lower leg.

The resident had three skin tears documented on the skin occurrence reports which occurred on September 12th, 13th, and 19th, 2014. The facility's investigation of the skin tears revealed one on the left hand caused by the resident's fingernails, one on the right lower leg inconclusive of origin, and one on the right forearm possibly could have resulted from a transfer earlier in the day. There were no environmental hazards that could have been eliminated and no identified staff member who caused an injury or documentation that a one staff assist transfer had ever taken place.

Resident D's Care Plan, Medication Administration Record, and Treatment Administration Record did have interventions in place. The resident's record and the observations on November 3rd and 4th, 2014 reflected the interventions were being completed. The licensed nurse does a weekly head to toe skin check on this resident.

Resident D was observed on November 4, 2014, while a licensed nurse performed a skin inspection on both arms and legs and there was no noted skin tears, bruises, or scratches.

Staff interviews were conducted in regards to the transfers of Resident #4. Staff stated that the resident is a two person extensive assist and none of the staff have ever tried to transfer her without two staff members.

Resident D's investigation lacked sufficient documentation to show the facility had any deficit practices and so the complaint for this resident is unsubstantiated.

3. Resident B's medical record and the facility's June through current month incident and accident reports were reviewed, staff interviews, and observations completed for the allegations of the resident being rushed in a wheelchair by the Certified Nurse Aide into the bathroom, with a result of a flaccid arm that sustained a skin tear on the door hinges. The resident's diagnoses included Cardiovascular Accident with left sided deficits, muscle weakness and abnormal gait.

The resident had five reports of skin occurrences, which included bruises and skin tears from June 29, 2014 to September 8, 2014. The facility's investigation of three of the skin occurrences documented the skin tear on the left leg, the bruise on the left shin and then a bruise and skin tear on the left arm had resulted from actions of staff members.

Resident B's Care Plan, Medication Administration Record, and Treatment Administration Record did not have interventions in place for a resident with residual left sided deficits and high risk skin concerns. The resident's record revealed conflicting documentation.

Resident B was observed on November 4, 2014, while a licensed nurse performed a skin inspection on both arms and legs and there was no noted skin tears, bruises, or scratches.

Resident B's investigation showed the facility had a deficient practice, which resulted in injuries and so the complaint for this resident is substantiated. Please refer to federal citation F323 as a result of the complaint investigation.

CONCLUSIONS:

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

ALLEGATION #2:

Resident C has a prosthetic arm and is at high risk of falls. This resident likes to go outside on the patio and is not to be left by himself. The complainant stated staff would take him out, or he would take himself out in his wheelchair, and leave him unattended. The complainant stated in September the resident was found on the ground, he had tipped his wheelchair over. The complainant stated the entire left side of his body was covered in bruises.

Resident F is a two person extensive assist via hooyer for transfers. The complainant stated during the week of October 20th, 2014 the identified resident fractured his ankle and the cause was unknown.

FINDINGS:

Resident C was independent with going outside and tending to the toinatoe plants the family provided for him. The resident's care plan prior to the incident maintained his independence with only a wander guard on the resident's wheelchair to notify staff he was going outside.

On September 14, 2014 at 3:30 p.m., the resident was found outside the front door to the facility tipped over in his wheelchair. There is a ramp at the front door with about a 10 degree incline and then a 10 inch drop off into gravel. On November 3 2014 at 2:30 p.m. the CNA who found the resident stated he had an arm full of tomatoes and appeared to get too close to the edge of the ramp. This resulted in the resident falling into the gravel on the side of the ramp. The resident did have abrasions and scrapes from the fall. The resident, prior to the incident, had gone outside almost daily to tend to the plants. He was able to let himself back into the building without assistance.

The area where the tomatoe plant were located did not have anything that would be a safety concern. The resident had two barrels of plants with green tomatoes on them that the resident could attend to.

Since the incident, the resident's care plan was changed to supervision when he was outside. The resident was interviewed on November 4, 2014 at 10:00 a.m. and was not happy that he could not go

outside as often as he had because of the restrictions. The resident's room had nuts, bolts and tools that would be more of a safety issue than going outside to tend his plants. This was discussed with the facility and the DON will look into decreasing restrictions.

Resident F sustained a fractured tibia and fibia on October 24, 2014 at 7:13 a.m. The Incident Report was reviewed, the CNA and RN who cared for the resident were interviewed. The resident was brought to the dining area as per routine. The resident was in a tilted Broda chair. He was to be brought to an upright position when he was set up at the dining table. The CNA set him up at the table and left to get another resident. A female resident was heard yelling in the dining room so the CNA went back and found the resident on the floor. The resident's hip and ankle were x-rayed and found to have a fracture of the tibia and fibia.

The CNA interviewed on November 4, 2014 at 10:35 a.m. said that she had been taking care of the resident since he was admitted at least 5 days a week. The resident was admitted on February 2, 2014. The morning routine was the same every day. The resident had bolsters and padding in the chair to prevent him from sliding out. The resident never tried to get out of the wheelchair before the incident. The CNA and RN could not determine how he came out of the chair.

Since the incident the resident's care plan interventions were changed to, "Put him in upright position for meals only when meal is served and he is observed by staff." (10/24/14)

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The complainant identified concerns related to the following resident:

Resident E-- in May 2014 or June 2014, this resident's leg was broken and required amputation. The complainant identified this resident as a two person extensive assist via Hoyer lift for transfers. The complainant stated two CNAs were terminated after this occurred for not using the Hoyer to transfer the identified resident. The complainant stated the CNAs were in-serviced to follow resident's care plans.

FINDINGS:

Resident E's incident was investigated and it was found the resident did sustain a fracture of the left femur on June 6, 2014. The injury occurred while two staff members were transferring Resident E to a shower chair. Review of the resident's care plan found the resident was a mechanical lift transfer and had been for several months prior to the incident.

David Green, Administrator
December 19, 2014
Page 6 of 7

The facility investigation found two CNAs were responsible for the injury and as a result they were both terminated.

For more information refer to Federal citation F 309 cited as a result of the complaint investigation.

CONCLUSIONS:

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

ALLEGATION #4:

The complainant stated the facility is not adequately staffed. The facility's census was thirty-two at the time of the investigation and there are three CNAs on the floor from 6 AM to 10 AM and then there are only two CNAs until 2 PM. The evening shift has two CNAs until 4 PM and then another CNA comes in from 4 PM to 8 PM and then there are only two CNAs until 10 PM.

FINDINGS:

The CNA schedules were reviewed for August 2014, September 2014, October 2014 and November 2014. The schedules confirm three CNAs on the floor from 6 AM to 10 AM and then there are two CNAs until 2 PM. The evening shift has two CNAs until 4 PM and then another CNA comes in from 4 PM to 8 PM and then there are only two CNAs until 10 PM.

The schedules also had a restorative CNA and a bath aide scheduled. There was adequate staffing to care for the residents and observations done on November 3rd and 4th, 2014 supported there were no care need issues identified.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #5:

The complainant stated the facility has "made more residents use hooyer lifts for transfers because it is more convenient and to make it easier on the staff." The complainant is concerned this affects residents' independence and some residents refuse to get out of bed because they are afraid of falling out of the hooyer lift and/or have received bruises and/or skin tears from the lift.

FINDINGS:

A list of all residents who used mechanical lifts for transfers was obtained from the facility. There were

David Green, Administrator
December 19, 2014
Page 7 of 7

eight residents on the list. The care plans for all of the residents were reviewed. Seven of the residents' care plans had implementation dates ranging from October 2013 to June 2014.

One of the eight residents was admitted to the facility on November 11, 2014 and was a mechanical lift. Therapy was working with this resident to improve his transfer skills and strength. The plan was to discontinue the mechanical lift at a future date.

The Director of Nurses was interviewed on November 4, 2014 at 3:30 p.m. and said the facility nursing staff and therapy evaluates the resident prior to starting a resident on a mechanical lift.

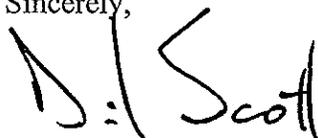
CONCLUSIONS:

Unsubstantiated. Allegation did not occur.

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

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

Sincerely,

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

DAVID SCOTT, RN, Supervisor
Long Term Care

DS/lj



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

DEBRA RANSOM, R.N., R.H.I.T., Chief
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PHONE 208-334-6626
FAX 208-364-1888

December 19, 2014

FILE COPY

David Green, Administrator
Owyhee Health & Rehabilitation Center
PO Box A
Homedale, ID 83628-2040

Provider #: 135087

Dear Mr. Green:

On **November 4, 2014**, a Complaint Investigation survey was conducted at Owyhee Health & Rehabilitation Center. Linda Hukill-Neil, RN and Arnold Rosling, RN, QIDP, conducted the complaint investigation.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00006729

ALLEGATION #1:

The complainant stated an aide working the evening shift at approximately 6:30 P.M. said the resident slid out of his wheelchair, a tall chair that leans back, at the breakfast table in the dining room at approximately 7 A.M. on October 23, 2014 or October 24, 2014. The resident hit the floor and told staff, "It hurts, it hurts." The facility took an X-ray (mobile) of the resident's hip that day, which didn't show a fracture. They took another X-ray (mobile) the next day, and the resident's right ankle was fractured.

FINDINGS:

The complaint was investigated on November 3, 2014 and November 4, 2014.

A total of fifteen hours were required to review the identified resident's medical records, incident and accident reports and to conduct staff interviews.

Interviews were conducted with the following:

- One CNA involved in the incident;
- One RN on duty at the time of the incident;
- Director of Nursing; and
- Medical Records designee.

The investigation found the resident the complainant identified sustained a fractured tibia and fibia on October 24, 2014, at 7:13 a.m. The Incident Report was reviewed, and CNA #3 and RN#2 who cared for the resident were interviewed.

The resident was brought to the dining area, as per routine, in a tilted Broda chair, which was to be brought to an upright position when he was set up at the dining table. CNA #3 set him up at the table and left to get another resident. A female resident was heard yelling in the dining room, so the CNA went back and found the resident on the floor. The resident's hip and ankle were X-rayed, which showed a fracture of the tibia and fibia.

CNA #3 was interviewed on November 4, 2014, at 10:35 a.m. and said she had been taking care of the resident at least five days a week since he was admitted. CNA #3 stated the resident had bolsters and padding in the chair to prevent him from sliding out, but the resident never tried to get out of the wheelchair. Based on CNA #3 and RN #2 interviews, it could not be determined how the resident came out of the chair.

Since the incident, the resident's care plan interventions were changed on October 24, 2014, to "Put him in upright position for meals only when meal is served and he is observed by staff." In addition, the CNA who cared for him stated that she was concerned about the fall. She also removed the sling that usually stayed in the wheelchair for the mechanical lift, as it could have been slick and contributed to the fall.

There were no indications that the resident had ever been in any other chairs other than the tilt Broda chair. The chair was purchased for the resident at a previous facility, and there was no documented evidence that the resident ever used any other chair.

CONCLUSIONS:

Substantiated. No deficiencies related to the allegation are cited.

David Green, Administrator
December 19, 2014
Page 3 of 4

ALLEGATION #2:

The complainant visited the resident on October 26, 2014, and stated she was told by a nurse who was on duty around 6:30 p.m. that she had left the complainant a message regarding the resident's fall and fractured ankle. The nurse asked if the complainant had received her message. The complainant stated she checked her home phone and her cell number messages and did not have any messages from the facility.

FINDINGS:

The resident's medical record was reviewed for contact information. There was documentation in the resident's medical record that the facility tried to contact the family twice and left messages, but no one called back. The family member called the facility on October 25 2014, at 7:10 p.m., and she was informed of the injury. During this call, it was discovered that the contact information had changed. The facility updated the contact information to the current phone number.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The complainant requested a copy of the nurses' notes detailing the fall and fracture incident from the evening RN who was on duty at 6:30 p.m. on October 26, 2014. The complainant did not receive the information she requested.

FINDINGS:

The Director of Nursing and the medical records staff were interviewed on October 4, 2014, at 10:00 a.m. The facility stated it did not receive a request for records either in writing or verbally. The Director of Nursing and the medical records staff said they would have no problem copying the information that the complainant requested. They further indicated that they copy records for residents and power-of-attorneys on a routine basis.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

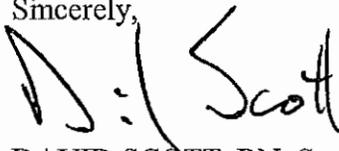
Based on the findings of the complaint investigation, deficiencies were cited and included on the

David Green, Administrator
December 19, 2014
Page 4 of 4

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

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

Sincerely,

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

DAVID SCOTT, RN, Supervisor
Long Term Care

DS/lj



IDAHO DEPARTMENT OF
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December 19, 2014

David Green, Administrator
Owyhee Health & Rehabilitation Center
PO Box A
Homedale, ID 83628-2040

FILE COPY

Provider #: 135087

Dear Mr. Green:

On **November 4, 2014**, a Complaint Investigation survey was conducted at Owyhee Health & Rehabilitation Center. Linda Hukill-Neil, RN, Arnold Rosling, RN, QIDP, conducted the complaint investigation.

The complaint was investigated on November 3, 2014 and November 4, 2014.

The following documentation was reviewed:

- Individual resident's medical records;
- Infection control policy and procedures;
- Staff's infection control in-services for September and October 2014;
- Isolation gown invoices; and
- Monthly Nosocomial Infection Reports from July 2014 to current.

Interviews were conducted with the following:

Two Certified Nurse Aides;
Infection Control Registered Nurse;
Director of Nursing; and
Medical records designee.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00006734

ALLEGATION #1:

The complainant stated a resident was admitted approximately three weeks ago (middle of September) with C-Diff. The complainant stated the building was searched and staff do not have the proper protective equipment, which includes gowns and shoe covers. The facility does have gloves and masks. The complainant stated the concern was reported to the nurses but nothing had been done.

FINDINGS:

The identified resident's medical record and the facility's infection control policy and procedures, infection control in-services and isolation gown invoices were reviewed; staff interviews were conducted and observations were completed for the allegations that the facility's lack of personal protective equipment (PPE) for use by staff and visitors with interaction of an infection precaution resident.

The identified resident was admitted to the facility with diagnoses of Clostridium Difficile.

On November 3, 2014, an observation of the identified resident's room and the medical record revealed there were no longer any infection precautions in place. The identified resident was in a private room with a private bathroom and sink since admission. The resident required two staff assist for transfers and personal cares. The identified resident was removed from isolation precautions on October 27, 2014.

The facility's infection control policy and procedures for infectious diseases in the long term care facility documented the following for acute diarrhea and Clostridium Difficile (C. diff) infections:

- Clean hands with soap and water or an alcohol-based hand rub before and after caring for every patient.
- Use Contact Precautions to prevent C. diff from spreading to other patients.
- Private room-- Yes, if resident's hygiene is poor or share a room only with someone else who also has C. diff.
- Mask-- No, only during procedures and patient care activities likely to generate splashes or sprays of blood, body fluids, secretions, especially suctioning, endotracheal intubation.
- Gown-- Yes, if soiling is likely. Healthcare providers will put on gloves and wear a gown over their clothing while taking care of patients with C. diff. Visitors may also be asked to wear a gown and gloves.
- Gloves-- Yes, for touching infective material.
- Infective Material-- Feces.
- When leaving the room, hospital providers and visitors remove their gown and gloves and clean their hands.

David Green, Administrator
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- Duration - Duration of illness.

The facility provided in-service attendance documentation for infection control that covered infection precautions, including contact precautions for C. diff. These in-services were completed on October 14, 2014 and October 20, 2014.

Two Certified Nurse Aides confirmed they had cared for the identified resident while the isolation precautions were in place. Both Certified Nurse Aides stated the resident had an isolation cart outside the room, which contained gloves and disposable yellow gowns. There was one day each CNA remembered that the facility did not have any disposable gowns, so the facility stocked the cart with cuffed long sleeved gowns, which fully covered the CNA's own clothing. Staff was not required to wear masks or shoe covers.

The Director of Nursing and a licensed nurse were interviewed regarding the facility's infection control policy and procedures, staff training and infection control monitoring. The facility provided documentation to support infection control issues were being addressed timely and appropriately. The Director of Nursing confirmed the facility had run out of disposable gowns, and the facility provided long sleeve protective gowns for two days. The facility had two residents at the same time who were admitted with Clostridium Difficile. Each resident had a private room, private bathroom and an isolation cart outside of their doorway. The facility placed an order for disposable gowns, but the first order had to be back ordered so the facility placed an expedited second order, and the gowns arrived the next day.

The facility did not need to provide protective shoe covers as protective gowns for staff and visitors were provided. The allegation could not be substantiated for lack of sufficient evidence.

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, LSW, QIDP, Supervisor
Long Term Care

LK/lj