



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 2038

December 2, 2013

Michael G. Andrus, Administrator
Franklin County Transitional Care
44 North First East
Preston, ID 83263-1326

Provider #: 135059

Dear Mr. Andrus:

On **November 22, 2013**, a Recertification, Complaint Investigation and State Licensure survey was conducted at Franklin County Transitional Care by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be one that comprises a pattern that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies, and a similar State Form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 3). **Please provide ONLY ONE completion date for each federal and state tag in column (X5) Completion Date, to signify when you allege that each tag will be back in compliance.** WAIVER RENEWALS MAY BE REQUESTED ON THE PLAN OF CORRECTION. After each deficiency has been answered and dated, the administrator should sign both Form CMS-2567 and State Form, Statement of Deficiencies and Plan of Correction in

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the spaces provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **December 16, 2013**. Failure to submit an acceptable PoC by **December 16, 2013**, may result in the imposition of civil monetary penalties by **January 6, 2014**.

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

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

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

- The administrator must sign and date the first page of both the federal survey report, Form

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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 **December 27, 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 **December 27, 2013**. A change in the seriousness of the deficiencies on **December 27, 2013**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **December 27, 2013** includes the following:

Denial of payment for new admissions effective **February 22, 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 **May 22, 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.

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

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Regional Office or the State Medicaid Agency beginning on **November 22, 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 **December 16, 2013**. If your request for informal dispute resolution is received after **December 16, 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

| | | | |
|--|---------------------------------|--|---|
| STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs | PROVIDER # 135059 | MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | DATE SURVEY COMPLETE: 11/22/2013 |
|--|---------------------------------|--|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER FRANKLIN COUNTY TRANSITIONAL CARE | STREET ADDRESS, CITY, STATE, ZIP CODE 44 NORTH 1ST EAST PRESTON, ID |
|--|---|

| | |
|---------------------|-----------------------------------|
| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES |
|---------------------|-----------------------------------|

F 281

483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS

The services provided or arranged by the facility must meet professional standards of quality.

This REQUIREMENT is not met as evidenced by:

Based on observation and staff interview, it was determined the facility failed to ensure professional standards of quality were maintained. This was true for 1 of 8 residents (#12) observed during the medication pass observation when a medication was initialed prior to administration. Failure to adhere to professional standards created the potential for minimal harm should the resident not receive the insulin injection. Findings included:

Resident #12's November 2013 through December 2013 recapitulated Physician Orders documented in part:
* Humalog Mix 75/25 12 units subcutaneous once a day in the evening.

On 11/20/13 at 4:06 p.m., LN #1 was observed as she prepared medication for Resident #12 which included Humalog insulin. It was observed on the MAR (Medication Administration Record) that the LN had initialed the medication as administered prior to actually administering the medication to Resident #12. The LN was asked if she had already initialed the medication at which she responded, "I do." The LN added the facility trains staff to initial after administering the medication, but she was trained elsewhere to initial the medication and if the resident does not actually receive it, to circle the initials.

Note: Informational Letter #97-3, dated April 16, 1997: The Medication Distribution Technique Clarification To Informational Letter, 96-14, from the Bureau of Facility Standards, stated, "The issue arose when the Board of Nursing received information that long term care facility staff were signing medications as given at the time of the medication preparation, not after the resident actually received the medication. ...the Board's expectation, and the accepted standard of practice, is that licensed nurses document those things they have done, not what they intend to do."

On 11/21/13 at 4:27 p.m., the Administrator, DON, and QMC were informed of the pre-initialing observation. However, no further information or documentation was provided which resolved the issue.

RECEIVED
DEC 16 2013
FACILITY STANDARDS

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

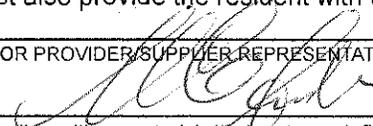
The above isolated deficiencies pose no actual harm to the residents

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135059 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 11/22/2013 |
| NAME OF PROVIDER OR SUPPLIER FRANKLIN COUNTY TRANSITIONAL CARE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 44 NORTH 1ST EAST PRESTON, ID 83263 | |
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| F 000 | <p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the annual federal recertification and complaint investigation survey of your facility.</p> <p>The surveyors conducting the survey were: Brad Perry, BSW, LSW, Team Coordinator Lauren Hoard RN, BSN</p> <p>The survey team entered the facility on November 18, 2013 and exited on November 22, 2013.</p> <p>Survey Definitions: ADL = Activities of Daily Living BID = Twice a Day BIMS = Brief Interview for Mental Status cm = Centimeters CNA = Certified Nurse Aide DON = Director of Nursing LN = Licensed Nurse MAR = Medication Administration Record MCG = Microgram MDS = Minimum Data Set assessment MEQ = Milliequivalent PO = By Mouth PRN = As Needed QMC = Quality Management Coordinator UTI = Urinary Tract Infection</p> | F 000 | | |
| F 156 SS=C | <p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the</p> | F 156 | <p>RECEIVED DEC 16 2013 FACILITY STANDARDS</p> <p><i>See Attached</i></p> | |

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



TITLE

Administrator

(X6) DATE

12-13-13

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 156 | <p>Continued From page 1</p> <p>notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5) (i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of</p> | F 156 | | |

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| F 156 | <p>Continued From page 2</p> <p>institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>This REQUIREMENT is not met as evidenced by: Based on review of the facility's admission agreement and staff interview, it was determined the facility failed to ensure residents were fully</p> | F 156 | | |

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| F 156 | <p>Continued From page 3</p> <p>informed of their rights in writing at the time of admission to examine results of the most recent survey. This was true for 9 of 9 sampled residents (#s 1-9) and all other residents residing in the facility. Findings included:</p> <p>The facility's admission agreement was reviewed on 11/20/13 as part of the standard survey process. The agreement did not include language informing residents of the right to examine results of the most recent survey.</p> <p>On 11/21/13 at about 10:46 a.m., the QMC was asked to point out on the admission agreement the resident right to examine the results of the most recent survey. After looking through the admission agreement with the surveyor and not finding the aforementioned resident's right, the QMC said she would look into it further. Later that day the surveyor was provided with an additional copy of the document containing Resident Bill of Rights from the admission agreement with a page folded over and a star next to the section that stated, "16. The resident has the right to request either orally or in writing and have access to all records that are about them within 24 hours (excluding weekends and holidays) and may buy copies of their records after 2 working days notice to the facility. The fee for copies shall not exceed the community standard for photocopies."</p> <p>On 11/21/13 at 3:32 p.m., the QMC was asked how the starred section of the admission agreement containing resident rights informed residents of their right to examine the results of the most recent survey at which she responded, "We tell them they can look at anything we have about them." The QMC added that the residents have a list of their rights and the facility goes over</p> | F 156 | | |

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| F 156 | Continued From page 4 those rights with them. On 11/21/13 at 4:27 p.m., the Administrator, DON, and QMC were informed of the issue with the admission agreement. However, no further information or documentation was provided that resolved the issue. | F 156 | | |
| F 167 SS=C | 483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility did not ensure the results of the recertification survey were readily accessible to residents. This deficient practice was true for any resident or their representative who may want to review the survey results, including 9 of 9 sample residents (#1 - 9). Findings included: On 11/18/13 at 3:15 PM, a Survey Results binder was located on the wall in the facility entrance foyer. Inside the binder was the last annual recertification survey plan of correction dated 10/26/12, which was separate from the survey | F 167 | | |

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| F 167 | <p>Continued From page 5 results. The results of the last annual recertification survey on 9/28/12 were not located in the binder.</p> <p>On 11/18/13 at 3:15 PM, the QMC was asked about the results of the missing survey results. The QMC said they had been there, but someone took them out and never returned them. She said she would make sure the results were put back in.</p> <p>On 11/19/13 at 1:32 PM, the survey results were still not found in the binder.</p> <p>On 11/19/13 at 2:20 PM, when the Administrator and DON were asked why the survey results were not in the binder, the DON asked the surveyor, "We don't?" The Administrator said they would get a copy in the binder.</p> <p>On 11/19/13 at 3:00 PM, the Administrator placed the missing survey in the binder, and replaced the binder on the wall.</p> <p>On 11/21/13 at 4:30 PM, the Administrator, DON, and QMC were informed of the surveyor's findings. No further information was provided.</p> | F 167 | | |
| F 176 SS=D | <p>483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE</p> <p>An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.</p> <p>This REQUIREMENT is not met as evidenced by:</p> | F 176 | | |

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| F 176 | <p>Continued From page 6</p> <p>Based on observation, record review and staff interview, it was determined the facility failed to ensure residents were assessed to determine if they were safe to self-administer medication. This was true for 1 of 9 (#1) sampled residents when Resident #1 was observed having an inhaler at the bedside. This failed practice created the potential for the resident to receive more than the prescribed amount of the inhaler medication. Findings included:</p> <p>Resident #1 was admitted to the facility on 3/5/13 with multiple diagnoses which included congestive heart failure, cerebrovascular accident (CVA), and multiple transient ischemic attacks.</p> <p>Resident #1's most recent quarterly MDS assessment, dated 8/15/13, documented in part:</p> <ul style="list-style-type: none"> * Severely impaired cognition with a BIMS score of 0; * Limited assistance of one person for bed mobility; * Independent with transfers, walking in room, and locomotion on the unit; * Supervision for walking in corridor and locomotion off the unit; and, * Extensive assistance with one person for dressing, toilet use, personal hygiene, and bathing. <p>A Multi Disciplinary Care Plan for Resident #1, dated 3/11/13, documented in part:</p> <ul style="list-style-type: none"> * Problems - Need for Monitoring related to: History of CVA; and, * Approaches/Interventions - "Give meds [medications] as ordered - no self-administration." <p>Resident #1's September 2013 through October 2013 recapitulated Physician Orders documented</p> | F 176 | | |

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| F 176 | <p>Continued From page 7 in part: * "Albuterol HFA [hydrofluoroalkane] MDI [Metered-Dose Inhaler] Aerosol - 2 puffs four time a day as needed."</p> <p>On 11/19/13 at 9:30 a.m., during an interview with Resident #1, an inhaler was observed next to the resident's bed on the armrest of a recliner. The resident expressed concern with coughing and wheezing at times.</p> <p>On 11/20/13 at 9:07 a.m., the inhaler was observed at Resident #1's bedside on the recliner next to the bed. The inhalant solution canister read, "Albuterol Sulfate." When asked about the inhaler, Resident #1 said she didn't use it unless she needed to because it, "Makes my heart beat fast."</p> <p>On 11/20/13 at 2:20 p.m., RNA #1 was asked where resident assessments for self-administration of medications were kept. The RNA said the care plan would indicate if the resident was able to self-administer medications.</p> <p>On 11/20/13 at 2:35 p.m., the Staff Development Coordinator (SDC) was interviewed about assessments to self-administer medications for Resident #1. The SDC said there were no documented assessments of determining the resident safe to self-administer medications, but the issue was discussed at MDT (Multi Disciplinary Team) meetings. The SDC stated, "She [Resident #1] can't remember if she's used it [inhaler] 2 seconds ago" and confirmed Resident #1 was not safe to use the inhaler on her own. The SDC was informed of the observations of Resident #1's inhaler at the bedside on 2 consecutive days.</p> | F 176 | | |
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| F 241 | Continued From page 9 On 11/20/13 at 3:35 PM CNA #6 was interviewed regarding the observation. CNA #6 stated, "No, I didn't knock...Normally I do knock." On 11/21/13 at 12:45 PM the DON was interviewed regarding the lack of knocking by staff. She stated, "They have been told and taught." On 11/21/13 at 4:30 PM, the Administrator, DON, and QMC were informed of the staff entering rooms without knocking. No other information was provided by the facility. | F 241 | | |
| F 272 SS=E | 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; Contenance; Disease diagnosis and health conditions; Dental and nutritional status; | F 272 | | |

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| F 272 | <p>Continued From page 10</p> <p>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 Documentation of participation in assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure side rails used for 5 of 9 (#s 2-6) sampled residents were assessed for safety. This had the potential to harm the residents due to the risk of limb entrapment in the side rails. Findings included:</p> <p>1. Resident #2 was admitted to the facility on 2/2/13 with multiple diagnoses including senile dementia, depression, and chronic pain.</p> <p>On 11/18/13 at 4:10 PM and throughout the survey process, top side rails on both sides of the resident's bed were observed in the upright position.</p> <p>The resident's Physician Orders for September and October 2013 (recapitulation orders) contained a 2/2/13 order for top side rails up to</p> | F 272 | | |

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| F 272 | <p>Continued From page 11 aid in bed mobility/enabler.</p> <p>The resident's care plan identified an approach for the problem area for ADL/Functional limitations. One of the interventions was top side rails for mobility.</p> <p>The resident's Physical Restraint Assessment and Evaluation, dated 11/8/13, did not include an assessment for side rail safety.</p> <p>2. Resident #4 was admitted to the facility on 4/11/13 with multiple diagnoses including pressure ulcer, traumatic brain injury, and paraplegia.</p> <p>On 11/19/13 at 8:00 AM and throughout the survey process, full side rails on both sides of the resident's bed were observed in the upright position.</p> <p>The resident's Physician Orders for November and December 2013, (recapitulation orders) contained a 4/11/12 order for full side rails up for safety reasons due to involuntary movement.</p> <p>The resident's care plan identified an approach for the problem area for Potential for Falls. One of the interventions was, "Full side rails for safety and to reduce potential for sliding out of bed."</p> <p>The resident's Physical Restraint Assessment and Evaluation, dated 10/9/13, did not include an assessment for side rail safety.</p> <p>3. Resident #5 was admitted to the facility on 8/9/06 with multiple diagnoses including fracture of vault of skull and persistent vegetative state.</p> | F 272 | | |

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| F 272 | <p>Continued From page 12</p> <p>On 11/19/13 at 10:40 AM and throughout the survey process, top side rails on one side of the resident's bed were observed in the upright position.</p> <p>The resident's Physician Orders for September and October 2013 (recapitulation orders) contained a 11/16/11 order for top side rails up to prevent falls due to involuntary movement.</p> <p>The resident's care plan identified an approach for the problem area for Potential for Falls. One of the interventions was, "Top side rails used to reduce potential for sliding out of bed."</p> <p>The resident's Physical Restraint Assessment and Evaluation, dated 10/24/13, did not include an assessment for side rail safety.</p> <p>4. Resident #3 was admitted to the facility on 4/12/10 with multiple diagnoses which included depression, anemia, congestive heart failure, and failure to thrive.</p> <p>On 11/19/13 at 8:22 a.m., and throughout the survey process, the top left side rail on the Resident #3's bed was observed in the upright position.</p> <p>Resident #3's November 2013 through December 2013 recapitulated Physician Orders documented in part: * Top side rail up to aid bed mobility/enabler.</p> <p>The Multi Disciplinary Care Plan for Resident #3, dated 4/27/10, documented in part: * Problems - ADL/Functional limitations; and, * Approaches/Interventions - Bed mobility: Top</p> | F 272 | | |

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| F 272 | <p>Continued From page 13 rails for mobility/positioning.</p> <p>A Physical Restraint Assessment and Evaluation form for Resident #3, most recently dated 8/20/13, did not include an assessment for side rail safety.</p> <p>5. Resident #6 was admitted to the facility on 11/1/13 with multiple diagnoses which included pancreatitis, left hip fracture, Lupus, and chronic vertigo and headaches.</p> <p>On 11/19/13 at 1:00 p.m., and throughout the survey process, the top right side rail on Resident #6's bed was observed in the upright position.</p> <p>Resident #6's Admission Orders, dated 11/1/13, documented in part: * Side rails - HOB (Head of Bed) up times 2 for positioning.</p> <p>The Patient Specific Initial Care Plan for Resident #6, dated 11/1/13, documented in part: * Restraint - Siderails (word highlighted) up (arrow pointing up and highlighted), Half (word highlighted).</p> <p>A New Admission note, dated 11/1/13, documented in part: * "She wants top siderails-consent signed."</p> <p>A Physical Restraint Assessment and Evaluation form for Resident #6, dated 11/14/13, did not include an assessment for side rail safety.</p> <p>On 11/20/13 at 10:10 a.m., the Resident Assessment Coordinator (RAC) was asked if Resident #6 had a side rail safety assessment at which she stated, "Yes, she does" and showed</p> | F 272 | | |

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| F 272 | Continued From page 14 the surveyor a consent form the resident had signed for use of side rails. The surveyor explained that the consent form was not a safety assessment at which the RAC responded, "It never even occurred to me" and said the facility did not have, "A formal form." On 11/21/13 at 10:44 a.m., the QMC was interviewed regarding side rail safety assessments. After discussion with the surveyor about the Physical Restraint Assessment and Evaluation form, the QMC stated, "Sounds like we're not documenting what you want." On 11/21/13 at 4:27 p.m., the Administrator, DON, and QMC were informed of the side rail safety assessment issues. However, no further information or documentation was provided which resolved the issue. | F 272 | | | |
| F 314 SS=D | 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure that residents did not acquire pressure | F 314 | | | |

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| F 314 | <p>Continued From page 15</p> <p>ulcers in the facility. This was true for 1 of 2 sampled residents (#1) reviewed for pressure ulcers when Resident #1 was observed with her heels resting on the mattress. This failed practice created the potential for harm due to a break in skin integrity puts the resident at risk for infection. Findings included:</p> <p>Resident #1 was admitted to the facility on 3/5/13 with multiple diagnoses which included transient ischemic attacks, hypertension, and congestive heart failure.</p> <p>Resident #1's most recent quarterly MDS assessment, dated 8/15/13, documented in part:</p> <ul style="list-style-type: none"> * Severely impaired cognition with a BIMS score of 0; * Limited assistance of one person for bed mobility; * Independent with transfers, walking in room, and locomotion on the unit; * Supervision for walking in corridor and locomotion off the unit; * Extensive assistance with one person for dressing, toilet use, personal hygiene, and bathing; * Resident at risk of developing pressure ulcers; * Resident had one or more unhealed pressure ulcers at Stage 1 or higher; * One Stage 3 pressure ulcer that was present upon admission; * One unstageable pressure ulcer with suspected deep tissue injury in evolution; and, * Skin and ulcer treatments of pressure reducing device for chair and bed, pressure ulcer care, and applications of ointments/medications other than to feet. <p>The Multi Disciplinary Care Plan for Resident #1,</p> | F 314 | | |

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| F 314 | <p>Continued From page 16 dated 3/11/13, documented in part: * Problems - Risk for skin breakdown. History of pressure ulcers on feet - has neuropathy; * Approaches/Interventions - "Keep Pressure off heels."</p> <p>A Risk Assessment for Pressure Ulcers for Resident #1, dated 3/12/13, documented the resident's risk of developing pressure ulcers. The Total of Points equaled 12 which indicated Resident #1 was at high risk.</p> <p>On 11/19/13 at 9:30 a.m. and 12:57 p.m., Resident #1 was observed lying in bed with her heels resting on the mattress.</p> <p>On 11/20/13 at 9:07 a.m. Resident #1 was again observed lying in bed with her heels resting on the mattress.</p> <p>On 11/20/13 at 11:51 a.m., LN #3 was asked how pressure is kept off of Resident #1's heels while in bed. The LN stated, "With pillows" and said staff were to monitor during the day and put pillows underneath Resident #1's heels when she's lying down. LN #3 added, "We need to work harder to put pillows under her and make it a priority."</p> <p>On 11/21/13 at 4:27 p.m., the Administrator, DON and QMC were informed of the issue with the resident's heels resting on the mattress despite care plan instruction. However, no further information or documentation was provided which resolved the issue.</p> | F 314 | | |
| F 315 SS=D | 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER | F 315 | | |

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| F 315 | <p>Continued From page 17</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, it was determined the facility did not ensure an indwelling catheter was only used when clinically indicated for 1 of 9 sampled residents (#8) and failed to provide catheter care as ordered for 1 of 9 sampled residents (#4). These failed practices had the potential to harm the resident if they developed urinary tract infections or other complications related to an indwelling catheter and inadequate catheter care. Findings included:</p> <p>1. Resident #8 was admitted to the facility on 3/11/13 with multiple diagnoses including depression, dementia, and hypertension.</p> <p>On 11/20/13 at 2:30 PM, the resident was observed in her room on her bed with catheter tubing running into a catheter bag attached to the side of her bed in a privacy cover.</p> <p>The resident's quarterly MDS assessment dated 9/19/13 documented the resident did not have an indwelling catheter and was frequently incontinent of bladder.</p> | F 315 | | |

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| F 315 | <p>Continued From page 18</p> <p>The resident's Bladder and Bowel Assessment dated 9/20/13 documented: "Bladder and bowel pattern at admission: Frequently incontinent of bowel and bladder. Wears briefs for security. Bladder and bowel pattern from last assessment: Frequently incontinent of bladder and continent of bowel. Comments: ...They [staff] report that she is frequently incontinent of urine but this schedule is still keeping her continent of bowel. Recently she was having some "seeping" of bowel. Laxatives were adjusted as staff were thinking that daily laxative was too much. The seeping was causing extreme irritation to her skin. Rash was cultured and found to have an infection. Currently she is receiving an antibiotic."</p> <p>Facility MDT (Multi-Disciplinary) Meeting notes for the resident documented the following: *Sept 9, 2013, "...Change more often." *Sept 12, 2013, "...Bottom is better. Continue changing her often." *Sept 17, 2013, "...Bathing everyday."</p> <p>The resident's physician Transitional Care Note dated 9/30/13, documented: "The patient does have some sore skin around the rectum that has been cultured and she is getting treatment for that. The nurses have been monitoring it and feel as though it is not staying very dry. They are wondering about having a catheter placed...Skin breakdown with yeast infection. Catheter was placed and okay with family. She will continue to receive the catheter while trying to get the wounds healed."</p> <p>Physician's Telephone Orders for the resident</p> | F 315 | | |

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| F 315 | <p>Continued From page 19 dated 9/30/13 documented, "Place catheter until rash resolved."</p> <p>Note: Interpretive guidance at F 315 documented a valid skin related medical justification for an indwelling catheter for more than 14 days would be a Stage III or IV pressure ulcer.</p> <p>The resident's Care Plan dated 9/30/13 documented a problem, a goal, and an approach/intervention, "At risk for UTI r/t [related to]: Indwelling catheter placed to allow skin lesions to heal on her peri-area...Reduce potential for UTI...Catheter care bid and prn."</p> <p>On 11/21/13 at 9:10 AM the DON was interviewed regarding the catheter issue. She stated the catheter was placed, "Because of skin breakdown." She also stated the plan was for the catheter to come out as soon as the rash had healed.</p> <p>2. Resident #4 was admitted to the facility on 4/11/12 with multiple diagnoses including pressure ulcers, traumatic brain injury, paraplegia and a history of UTI.</p> <p>On 11/18/13 at 4:00 PM, the resident was observed in her room on her bed with catheter tubing running into a catheter bag attached to the side of her bed in a privacy cover.</p> <p>The resident's quarterly MDS assessment dated 10/10/13 documented the resident had an indwelling catheter.</p> <p>The resident's local hospital Operative Report dated 9/17/13 documented, "...female who is mentally and physically disabled has a</p> | F 315 | | |

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| F 315 | <p>Continued From page 20</p> <p>neurogenic bladder, which has been treated with chronic catheterization for some time. She now presents for placement of a suprapubic tube."</p> <p>The resident's October and November 2013 MAR's and Physician Orders documented with a start date of 9/17/13. "Supr[a] Pubic Cath[eter] Care BID."</p> <p>On the resident's October and November 2013 MAR, catheter care was not documented to be done for one of two opportunities on 10/7, 10/19, 11/7, 11/8, and 11/13.</p> <p>On 11/21/13 at 9:03 AM the DON was interviewed regarding the missed catheter care issue. She stated catheter care was completed by the staff, "...but didn't document."</p> <p>On 11/21/13 at 4:30 PM, the Administrator, DON, and QMC were informed of the lack of medical justification for the catheter usage and the lack of following catheter care orders. No further information was provided.</p> | F 315 | | |
| F 323 SS=E | <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by:</p> | F 323 | | |

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| F 323 | <p>Continued From page 21</p> <p>Based on observation and staff interview, it was determined the facility failed to ensure the resident environment remained as free of accident hazards as possible when equipment not in use was parked in the hallways blocking handrails. This was true for 2 of 9 sampled residents (#s 1 and 2) and any other residents who used A and B hallways for independent mobility. This failure created the potential for more than minimal harm should residents slip, trip and fall and not have access to handrails.</p> <p>On 11/19/13 the following observations were made of equipment not in use in the A hallway:</p> <ul style="list-style-type: none"> * 8:05 a.m., a large Hoyer lift was parked against the wall between room 7 and a linen closet which blocked the handrail; * 8:07 a.m., a Reliant RPA 600 lift was parked against the wall between the foyer entrance and room 17 which blocked the handrail. Additionally, a white shower chair, a black shower chair, and a wheelchair were parked against the wall between room 16 and room 17, across from the shower room, which blocked the handrail; * 8:25 a.m., an additional white shower chair was parked near the Reliant RPA 600 lift which blocked the handrail between the foyer entrance and room 17; * 8:50 a.m., the Reliant RPA 600 lift was still parked against the wall between the foyer entrance and room 17 which blocked the handrail; * 8:56 a.m., the large Hoyer lift was still parked against the wall between room 7 and the linen closet which blocked the handrail; * 9:18 a.m., a black chair with long handles and wheels was parked against the wall near room 17 which blocked the handrail. A staff member brought a shower chair out of the shower room | F 323 | | |

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| F 323 | <p>Continued From page 22</p> <p>and parked it behind the black chair with long handles and wheels which blocked more of the handrail;</p> <p>* 9:55 a.m., the large Hoyer lift continued to be parked against the wall between room 7 and the linen closet which blocked the handrail. A Reliant RPA 600 lift was parked behind the large Hoyer lift with the front end sticking out in the hallway, while the back end blocked the handrail;</p> <p>* 12:00 p.m., a large Hoyer lift was parked between room 6 and room 7 which blocked the handrail. A second large Hoyer lift was parked directly across the hall from the other large Hoyer lift which blocked a large portion of the hallway;</p> <p>* 1:47 p.m., a Reliant RPA 600 lift was parked next to room 8 and blocked the oxygen transfill room and the exit door at the end of the hall. Additionally, a wheelchair was parked near room 16 which blocked the handrail;</p> <p>* 2:44 p.m., the wheelchair parked near room 16 continued to block the handrail; and,</p> <p>* 3:30 p.m., a Reliant RPA 600 lift was parked between room 14 and the restorative closet which blocked the handrail.</p> <p>Similar observations were made of equipment parked in the A hallway which blocked handrails on 11/20/13 and 11/21/13.</p> <p>On 11/20/13 at 1:20 p.m., a Reliant RPA 600 lift was parked inside of room 14 while the resident in that room slept in bed. Additionally, a sit-to-stand lift was parked inside of room 3 with the resident in that room sleeping in a recliner.</p> <p>On 11/19/13 the following observations were made of equipment not in use in the B hallway:</p> <p>* 9:10 a.m., a sit-to-stand lift was parked next to room 31 which blocked the handrail;</p> | F 323 | | |

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| F 323 | <p>Continued From page 23</p> <p>* 1:45 p.m., a large Hoyer lift was parked near room 32 which blocked the handrail, and additional large Hoyer lift was parked between room 24 and room 25 with the front end sticking out into the hallway;</p> <p>* 3:43 p.m., a Reliant RPA 600 lift was parked between room 18 and room 19 which blocked the handrail.</p> <p>Similar observations were made of equipment parked in the B hallway which blocked handrails on 11/20/13 and 11/21/13.</p> <p>On 11/21/13 at 11:20 a.m., CNA #7 was asked where Hoyer lifts and equipment were stored when not in use. The CNA said the equipment was stored in empty rooms and if there were no empty rooms, the equipment was stored in a resident's room when it was not occupied.</p> <p>On 11/21/13 at 12:50 p.m., the DON was asked where Hoyer lifts and equipment were stored when not in use. The DON said the equipment was stored in resident rooms because there was a, "limited amount of space" within the facility.</p> <p>On 11/21/13 at 4:27 p.m., the Administrator, DON, and QMC were informed of the equipment observations. However, no further information or documentation was provided which resolved the issue.</p> | F 323 | | | |
| F 329 SS=D | <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>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</p> | F 329 | | | |

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| F 329 | <p>Continued From page 24</p> <p>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.</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 staff interview, it was determined the facility failed to ensure 3 of 9 sampled residents (#s 1, 6 and 9) received only those medications for which there existed a clinical indication for use. This failed practice potentially put residents at risk for decline resulting from adverse consequence of unnecessary medications which could lead to psychological or physical harm. Findings included:</p> <p>1. Resident #1 was admitted to the facility on 3/5/13 with multiple diagnoses which included multiple transient ischemic attacks, hypertension, dementia, sleep disorder, and congestive heart</p> | F 329 | | |

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| F 329 | <p>Continued From page 25 failure.</p> <p>Resident #1's September 2013 through October 2013 recapitulated Physician Orders documented in part:</p> <ul style="list-style-type: none"> * "3/5/2013 - Asprin EC 81 MG PO Once A Day;" * "3/5/2013 - Prevacid 30 MG (Lansoprazole) PO Once A Day;" * "3/5/2013 - Levothyroxine 100 MCG (0.1 MG) PO Once A Day;" * "3/5/2013 - Nasacort AQ (Triamcinalone) One Spray Nasally Daily At Bedtime;" * "6/5/2013 - Lanoxin 0.125 MG (Digoxin) PO Once Every Other Day;" * "3/5/2013 - Motrin 600 MG (Ibuprofen) PO Every 6 Hours As Needed;" * "3/5/2013 - Lasix 80 MG (Furosemide) PO Twice Daily;" * "3/5/2013 - Albuterol 0.083% INH SOLN (Albuterol Sulfate 2.5 MG/3 ML.) Via SVN Every 4 Hours As Needed;" * "3/5/2013 - Albuterol HFA MDI Aerosol - 2 Puffs Four Time A Day As Needed;" * "3/5/2013 - Tylenol 650 MG PO Every 4 Hours As Needed;" * "4/4/2013 - Trazodone 50 MG PO Daily At Bedtime;" and, * "5/30/2013 - Arginade Oral Twice Daily." <p>The November 2013 MAR for Resident #1 documented in part:</p> <ul style="list-style-type: none"> * "3/5/2013 - Asprin EC 81 MG PO Once A Day;" * "3/5/2013 - Prevacid 30 MG (Lansoprazole) PO Once A Day;" * "3/5/2013 - Levothyroxine 100 MCG (0.1 MG) PO Once A Day;" * "3/5/2013 - Nasacort AQ (Triamcinalone) One Spray Nasally Daily At Bedtime;" * "6/5/2013 - Lanoxin 0.125 MG (Digoxin) PO | F 329 | | | |

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| F 329 | <p>Continued From page 26</p> <p>Once Every Other Day;"</p> <ul style="list-style-type: none"> * "3/5/2013 - Motrin 600 MG (Ibuprofen) PO Every 6 Hours As Needed;" * "3/5/2013 - Lasix 60 MG (Furosemide) PO Twice Daily;" * "3/5/2013 - Albuterol 0.083% INH SOLN (Albuterol Sulfate 2.5 MG/3 ML.) Via SVN Every 4 Hours As Needed;" * "3/5/2013 - Albuterol HFA MDI Aerosol - 2 Puffs Four Time A Day As Needed;" * "3/5/2013 - Tylenol 650 MG PO Every 4 Hours As Needed;" * "4/4/2013 - Trazodone 50 MG PO Daily At Bedtime;" and, * "5/30/2013 - Arginade Oral Twice Daily." <p>The medical diagnoses for these medications was not found on either document.</p> <p>2. Resident #6 was admitted to the facility on 11/1/13 with multiple diagnoses which included pancreatitis, left hip fracture, Lupus, and chronic vertigo and headaches.</p> <p>The Admission Orders for Resident #6, dated 11/1/13, documented in part:</p> <ul style="list-style-type: none"> * "Primax 500 MG IV [intravenous] Q [every] 6 [hours] x 6 wks [weeks];" * "Cyclobenzaprine 10 MG PO TID [three times a day];" * "Valium 5 MG PO Q [every] Day;" * "Lasix 40 MG PO Q [every] Day;" * "Gabapentin 300 MG PO BID [two times a day];" and * "KCL 10 MEQ PO Q [every] Day." <p>Resident #6 ' s November 2013 MAR documented in part:</p> <ul style="list-style-type: none"> * "11/1/13 - Primaxin 500 MG IV [intravenous] Q | F 329 | | |
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| F 329 | <p>Continued From page 27</p> <p>[every] 6 hrs [hours] x 6 wks [weeks];"</p> <p>* "11/1/13 - Cyclobenzepine 10 MG PO TID [three times a day];"</p> <p>* "11/1/13 - Lasix 40 MG PO Q [every] Day;"</p> <p>* "11/1/13 - Gabapentin 300 MG PO BID [two times a day];"</p> <p>* "11/1/13 - Valium 5 MG PO Q [every] Day;" and,</p> <p>* "11/1/13 - KCL 10 MEQ PO Q [every] Day."</p> <p>The medical diagnoses for these medications was not found on either document.</p> <p>3. Resident #9 was admitted to the facility on 6/20/13 with multiple diagnoses including dementia with Lewy bodies and other organic psychotic condition.</p> <p>The resident's November and December 2013 Physicians Orders (recapitulation) documented, "6/20/2013-Seroquel 200 MG (Quetiapine) PO [by mouth] Twice A Day" and "9/10/2013-Trazodone 150 MG Daily At Bedtime."</p> <p>The resident's November 2013 MAR documented, "6/20/2013-Seroquel 200 MG (Quetiapine) PO [by mouth] Twice A Day" and "9/10/2013-Trazodone 150 MG Daily At Bedtime."</p> <p>The medical diagnoses for these medications were not found on either document.</p> <p>On 11/21/13 at 8:55 AM, the DON was interviewed regarding the diagnosis issue. She asked, "You can't find them?" She then stated, "We evidently need to fix that."</p> <p>On 11/21/13 at 4:30 PM, the Administrator, DON, and QMC were informed of the diagnosis issue. No further information was provided.</p> | F 329 | | |

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| F 387 SS=D | <p>483.40(c)(1)-(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT</p> <p>The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter.</p> <p>A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility did not ensure residents were seen by their physician's as frequently as required. This was true for 3 of 6 residents (#s 2, 4, & 5) sampled for frequency of physician's visits. The deficient practice had the potential to cause more than minimal harm when the resident's multiple medical issues were not monitored by a physician. Findings included:</p> <p>1. Resident #2 was admitted to the facility on 2/2/13 with multiple diagnoses including senile dementia, depression, and chronic pain.</p> <p>A review of physician visits for the resident revealed: The resident was seen by the physician on 2/14/13 and was not seen again until 4/19/13, 64 days later.</p> <p>On 11/21/13 at 9:00 AM the DON was interviewed regarding the lack of visits for Resident #2. She stated, "He should have had one."</p> <p>2. Resident #4 was admitted to the facility on</p> | F 387 | | |

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| F 387 | <p>Continued From page 29</p> <p>4/11/12 with multiple diagnoses including pressure ulcers, traumatic brain injury, paraplegia and a history of UTI.</p> <p>A review of physician visits for the resident revealed: The resident was seen by the physician on 7/12/13 and was not seen again until 9/30/13, 80 days later.</p> <p>On 11/21/13 at 9:03 AM the DON was interviewed regarding the lack of visits for Resident #4. She said the resident had a change in doctors and would search the medical record. At 1:40 PM, the DON provided the surveyor with the physician progress notes from the previous mentioned dates, but was unable to provide any other documentation of a physician visit between the ones in question.</p> <p>3. Resident #5 was admitted to the facility on 8/9/06 with multiple diagnoses including fracture of vault of skull and persistent vegetative state.</p> <p>A review of physician visits for the resident revealed: The resident was seen by the physician on 4/23/13 and was not seen again until 7/24/13, 91 days later.</p> <p>On 11/21/13 at 9:00 AM the DON was interviewed regarding the lack of visits for Resident #5. She stated, "He [the doctor] should have done something in June."</p> <p>On 11/21/13 at 4:30 PM, the Administrator, DON, and QMC were informed of the surveyor's findings. No further information was provided.</p> | F 387 | | |

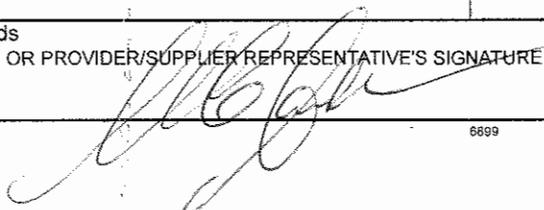
Bureau of Facility Standards

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001210 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 11/22/2013 |
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| C 000 | <p>16.03.02 INITIAL COMMENTS</p> <p>The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2.</p> <p>The following deficiencies were cited during the State licensure and complaint survey of your facility.</p> <p>The surveyors conducting the survey were: Brad Perry, BSW, LSW, Team Coordinator Lauren Hoard, RN, BSN</p> | C 000 | | |
| C 117 | <p>02.100,03,c,i Fully Informed of Rights</p> <p>i. Is fully informed, as evidenced by the patient's/resident's written acknowledgement, prior to or at the time of admission and during his stay, of these rights and of all rules, regulations and minimum standards governing patient/resident conduct and responsibilities. Should the patient/resident be medically or legally unable to understand these rights, the patient's/resident's guardian or responsible person (not an employee of the facility) has been informed on the patient's/resident's behalf;</p> <p>This Rule is not met as evidenced by: Refer to F156 as it relates to resident right to examine the most recent survey.</p> | C 117 | <p><i>See Attached</i></p> | |
| C 125 | <p>02.100,03,c,ix Treated with Respect/Dignity</p> <p>ix. Is treated with consideration, respect and full recognition of his</p> | C 125 | | |

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



TITLE

Administrator

(X6) DATE

12-13-13

Bureau of Facility Standards

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| NAME OF PROVIDER OR SUPPLIER FRANKLIN COUNTY TRANSITIONAL CARE | STREET ADDRESS, CITY, STATE, ZIP CODE 44 NORTH 1ST EAST PRESTON, ID 83263 |
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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 125 | Continued From page 1 dignity and individuality, including privacy in treatment and in care for his personal needs; This Rule is not met as evidenced by: Refer to F241 regarding staff walking into resident rooms without knocking. | C 125 | | |
| C 733 | 02.154,02,b Frequency of Physician Visits b. Each skilled nursing patient shall be seen by the attending physician at least once every thirty (30) days for the first ninety (90) days following admission. Thereafter, an alternative schedule may be adopted for patient/ resident visits based on physician's determination of need, and so justified in the patient's/resident's medical record. At no time may visits exceed ninety (90) day intervals. All physicians' visits shall be recorded in the patient's/ resident's medical record, with a physician's progress note. This Rule is not met as evidenced by: Refer to F387 regarding timely physician visits. | C 733 | | |
| C 779 | 02.200,03,a,i Developed from Nursing Assessment i. Developed from a nursing assessment of the patient's/resident's needs, strengths and weaknesses; This Rule is not met as evidenced by: Refer to F272 regarding side rail safety assessments. | C 779 | | |
| C 789 | 02.200,03,b,v Prevention of Decubitus | C 789 | | |

Bureau of Facility Standards

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001210 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 11/22/2013 |
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| NAME OF PROVIDER OR SUPPLIER FRANKLIN COUNTY TRANSITIONAL CARE | STREET ADDRESS, CITY, STATE, ZIP CODE 44 NORTH 1ST EAST PRESTON, ID 83263 |
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|--------------------|---|---------------|---|--------------------|
| C 789 | Continued From page 2 v. Prevention of decubitus ulcers or deformities or treatment thereof, if needed, including, but not limited to, changing position every two (2) hours when confined to bed or wheelchair and opportunity for exercise to promote circulation; This Rule is not met as evidenced by: Refer to F314 as it relates to preventing pressure ulcers. | C 789 | | |
| 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 preventing accidents. | C 790 | | |
| C 797 | 02.200,03,c Documentation of Nursing Assessments c. Nursing staff shall document on the patient/resident medical record, any assessments of the patient/resident, any interventions taken, effect of interventions, significant changes and observations and the administration of medications, treatments and any other services provided. Entries shall be made at the time the action occurs and shall be signed by the person making the entry and shall provide the time and date of the occurrence. At a minimum, a monthly summary of the patient's/resident's condition and reactions to care shall be written by a licensed nursing staff person. | C 797 | | |

Bureau of Facility Standards

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001210 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____ | (X3) DATE SURVEY COMPLETED 11/22/2013 |
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|--------------------|---|---------------|---|--------------------|
| C 797 | Continued From page 3 This Rule is not met as evidenced by: Refer to F281 as it relates to initialing a medication as administered prior to being administered. | C 797 | | |
| C 798 | 02.200,04,a MEDICATION ADMINISTRATION Written Orders 04. Medication Administration. Medications shall be provided to patients/residents by licensed nursing staff in accordance with established written procedures which shall include at least the following: a. Administered in accordance with physician's dentist's or nurse practitioner's written orders; This Rule is not met as evidenced by: Refer to F329 as it relates to having a correlating diagnosis for each medication. | C 798 | | |
| C 835 | 02.201,02,i Meds in Possession of Resident Limitations i. No medication shall be in the possession of the patient/resident unless specifically ordered by the physician on the patient's/resident's medical record, and in no case shall exceed two (2) units of dosage. All such medications shall be individually packaged by the pharmacist in units of dose, labeled with the patient's/resident's name, unit of dose, and date of distribution. The charge nurse shall maintain an inventory of these drugs on the patient's/resident's medical record. | C 835 | | |

Bureau of Facility Standards

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|-------|--|-------|--|--|
| C 835 | Continued From page 4 This Rule is not met as evidenced by: Refer to F176 as it relates to self-administration of medications. | C 835 | | |
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PLAN OF CORRECTION FOR THE STATE OF IDAHO - FRANKLIN COUNTY MEDICAL CENTER - NURSING HOME

Date of Survey: 11-22-30

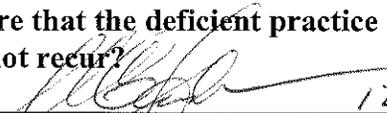
Opportunity to Correct: 12-16, 2013

POC deadline: 12-16-2013

Criteria: Include dates when corrective action will be completed.

1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?
2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken?
3. What measures will be put into place or what systemic changes we will make to ensure that the deficient practice does not recur?
4. How the corrective actions(s) will be monitored to ensure the deficient practice will not recur?
5. Date corrective action will be completed

Signature of Administrator



12-13-13

| TAG NUMBER | SCOPE/ SEVERITY | RESIDENT IDENTIFIERS | CRITERIA | FACILITY RESPONSE AND CORRECTIONS- |
|------------|-----------------|----------------------|----------|---|
| F156 | C | #1-9 | | Resident Rights to survey information |
| | | | 1. | The facility has had survey results available to the residents. We did not have the statement that the resident had the right to the results in the Admission Bill of rights that they receive. The admission Bill of Rights given to residents and/or representatives has been adjusted to contain this statement. |
| | | | 2. | All residents could be affected by this. The residents and/or representatives have been informed of this change and a copy of the new Bill of Rights. See attached letter and new form |
| | | | 3. | The new Bill of Rights form has replaced the old form and will be given to new residents and/or representatives. |
| | | | 4. | All new residents will be audited for weekly X4; monthly X1 by the Resident Assessment Coordinator(RAC) to ensure that the new bill of rights has been used. These audits will be forwarded to the Quality Management committee every month for 2 months |
| | | | 5. | COMPLETION DATE = 12-16-2013 |
| F167 | C | #1-9 | | Right to Survey Results |
| | | | 1. | The facility does have the Survey Results in a book in the foyer as you come into the facility and it is accessible to wheelchair residents. They have always had access to the notebook, but the results of the most recent survey had been taken out. This was fixed during the survey. |
| | | | 2. | All residents could be affected by this. All residents who are interviewable were informed during a special meeting on 12-11-2013 regarding survey results. See attached minutes and the letter. |
| | | | 3. | The book will be checked weekly X 2 to ensure that the survey results are in the book. |
| | | | 4. | Will be monitored for weekly x2 and then monthly X 2 by QM coordinator to ensure the survey book is complete. Data will be presented at the QM committee meeting. |
| | | | 5. | COMPLETION DATE = 12-16-2013 |
| F176 | D | 1 | | Resident Self Administer Drugs |
| | | | 1. | Resident #1 was informed that nurses cannot leave medications in her room. See attached notes |
| | | | 2. | All residents could be affected by this practice - see #3 for corrective actions taken. There are 5 |

| TAG NUMBER | SCOPE/ SEVERITY | RESIDENT IDENTIFIERS | CRITERIA | FACILITY RESPONSE AND CORRECTIONS- |
|------------|-----------------|----------------------|----------|--|
| | | | | residents who can self-administer. |
| | | | 3. | All residents who are interviewable were informed during a special meeting on 12-11-2013 regarding medications being left in room and why they cannot be left in rooms unless someone has self-administration privileges. The ADMISSION Rules and Services document was reviewed with the nursing staff. This information has been sent to all responsible parties as well. See attached minutes and letter sent to families. The nurses have also been coached on how to work with residents who have dementia who want their medication left in their room. See In-service of nurses coached The ADMISSION Rules and Services document will be added to the nurse orientation information. |
| | | | 4. | All rooms will be monitored daily X 3; weekly for 4 weeks and monthly X2 to ensure no medications are left in rooms or common areas except those rooms where residents have self-administration privileges by the Director of Nursing (DON). Data will be presented at the QM committee meeting. |
| | | | 5. | COMPLETION DATE =12-16-2013 |
| F241 | D | 4,9,11 | | Dignity and Respect of Individuality |
| | | | 1. | The residents affected in the past cannot have this changed. |
| | | | 2. | All residents could be affected by this. |
| | | | 3. | Informed CNA's and nurses regarding how privacy and respect for residents is important. Discussed the protocol for entering into a resident's room which is, knocking on the door and announcing yourself to the resident before entering any room . See attached inservice. |
| | | | 4. | Resident's privacy will be monitored daily X 5, weekly X 4 by the DON and QMC (Quality Management Coordinator). Data will be presented at the QM committee meeting. Entering into a resident's room properly will be discussed at staff meeting X 2 months to reinforce our current procedure. |
| | | | 5. | COMPLETION DATE =12-16-2013 |
| F272 | E | #2-6 | | Comprehensive Assessment – Residents assessed for side rail safety |
| | | | 1. | Residents # 2, 3, 4, 5, and 6 have been assessed for safety using side rails. See attached form |
| | | | 2. | All Residents using side rails could be affected by this. All residents using side rails were assessed. |
| | | | 3. | Within 5 days of admission and during their quarterly MDS assessments, all residents will be assessed for side rail safety. The MDT meeting Record has been revised to reflect this change. See attached form. The Physical Restraint Assessment and evaluation form has been revised. See attached form. |
| | | | 4. | The restorative aides will monitor all new admissions and quarterly assessments for X 4 weeks, and monthly X 2. All results will be forwarded to the Quality Management Committee. |
| | | | 5. | COMPLETION DATE =12-16-2013 |
| F314 | D | #1 | | Treatment to Prevent Pressure Sores |
| | | | 1. | Resident # 1 was reevaluated by the RAC (Resident Assessment Coordinator) and her care plan has been updated to reflect her current ambulatory status. CNA's made aware to offer heels off |

| TAG NUMBER | SCOPE/ SEVERITY | RESIDENT IDENTIFIERS | CRITERIA | FACILITY RESPONSE AND CORRECTIONS- |
|------------|-----------------|----------------------|----------|---|
| | | | | bed and shoes off when in bed. |
| | | | 2. | All residents who are at risk for skin breakdown could be affected by this. See 3. For corrective action |
| | | | 3. | All residents will be offered to have their heels off their beds three times a day while awake. The nurses and CNA's were made aware of the changes of offering three times a day and reporting to the nurse after they offered. |
| | | | 4. | The RN charge nurses will monitor all residents CNA charting daily for 10 days and Monthly X 1 to ensure that the CNA's are following the care plan by relieving pressure on resident's heels. Results will be forwarded to the QM committee. |
| | | | 5. | COMPLETION DATE ==12-16-2013 |
| F315 | D | #8,4 | | No catheter, Prevent UTI |
| | | | 1. | Resident #8 has had her catheter secondary to her excoriated skin which has been causing her pain. MDS team is getting an assessment from a urologist to explain why she is incontinent and offer alternatives to a foley catheter. See appointment for urologist. Resident #4 has had her superpubic catheter since 9-17-2013 and the CNA's are now performing the superpubic cath care on days and evenings and PRN on NOC. See attached CNA record for Resident #4. |
| | | | 2. | All Residents with indwelling catheters could have a problem with assessments and Cath care. We have 8 residents with indwelling catheters. All resident charts were checked and they have valid medical justification related to not being able to empty their bladder. |
| | | | 3. | All new admissions and indwelling catheters ordered will be monitored to ensure that valid medical justification is given for an indwelling catheter and that catheter care is being performed on all residents with urinary catheters. |
| | | | 4. | QMC will monitor daily X 10 days and weekly X 4 to ensure that urinary catheter care is being performed and day and evening shifts and that if urinary catheters are inserted that there is a consent, medical justification . Report forward to Quality Management Committee. |
| | | | 5. | COMPLETION DATE = 12-16-2013 |
| F329 | E | 1,6,9 | | Free from Unnecessary Drugs |
| | | | 1. | The physicians of residents 1, and 6 reviewed the medications that were being given and provided indications for use. See attached Physician orders. Resident # 9 was sent to hospital on 12-09-2013 and has not returned yet. We are unable to look at her physician orders at this time. |
| | | | 2. | This could affect every resident receiving medication therapy. See #3 for Corrective action taken. |
| | | | 3. | Our Medical Director for Long Term Care and other physicians who have residents, reviewed the medications that their residents were receiving, to ensure all have indications for use. All licensed staff were in serviced. Medications without indications will be brought to the physician to give an indication for use. Medical Director reviewed with staff on 12-13-13 |
| | | | 4. | We will monitor daily for 10 days on all new orders for each resident and then weekly X 3 to insure |

| TAG NUMBER | SCOPE/ SEVERITY | RESIDENT IDENTIFIERS | CRITERIA | FACILITY RESPONSE AND CORRECTIONS- |
|------------|-----------------|----------------------|----------|---|
| | | | | that all medications have an indication for use by the NOC charge nurse. All results will be forwarded to the QM committee. |
| | | | 5. | COMPLETION DATE = 12-16-2013 |
| F323 | E | #1, #2 | | Free of Accidents, Hazard |
| | | | 1. | Residents #1 and 2 have had their handrails free from being blocked. The nursing staff have been informed that no devices can block the handrails, or exits |
| | | | 2. | All residents could be affected by this. Laundry and Maintenance personnel with the DON examined areas that could be used to store the lifts that are used to move residents. An area down A hall and B hall has been remodeled to allow placement of the lifts without interfering with exits or handrails. See pictures of remodeling. The staff has been reminded that hallways must be clear. See attached staff meeting. The residents have also been informed to keep hallways clear. See attachment. |
| | | | 3. | See # 2. Above corrective action put into place to ensure deficient practice does not recur. |
| | | | 4. | The DON will monitor the hallways for 10 days and 4 weeks to ensure handrails are not blocked and hallways must clear. The data will be forwarded to the Quality Management Committee. |
| | | | 5. | COMPLETION DATE = 12-16-2013 |
| F387 | D | #2,4 and 5 | | Frequency and Timeliness of Physician visits |
| | | | 1. | Residents # 2, 4 and 5 have been visited by their physicians in November 2013. See attached notes |
| | | | 2. | All residents could be affected by the practice. Medical director attended the survey exit conference and was made aware of the problem. |
| | | | 3. | The secretaries of the various physician practices will block time for their doctors to see there residents in a timely manner. |
| | | | 4. | The QMC will audit daily X 10, weekly X 4 and monthly X 2 for timeliness of visits and the Medical Director will report in the Medical Staff and Board the results of the audits. |
| | | | 5. | COMPLETION DATE = 12-16-2013 |
| C117 | | | 1,2,3,4 | See 156 F156 - see below |
| | | | 5. | COMPLETION DATE = 12-16-2013 |
| C125 | | | 1,2,3,4, | See F241 |
| | | | 5. | COMPLETION DATE = 12-16-2013 |
| C733 | | | 1,2,3,4. | See F387 |
| | | | 5. | COMPLETION DATE = 12-16-2013 |
| C779 | | | 1,2,3,4 | See F 272 |
| | | | 5. | COMPLETION DATE = 12-16-2013 |

F156 comment approved via phone with MURELL GARVIS, DMS on 1/6/14 at 11:00 AM. BRAD PERRY, SURVEYOR

| TAG NUMBER | SCOPE/ SEVERITY | RESIDENT IDENTIFIERS | CRITERIA | FACILITY RESPONSE AND CORRECTIONS- |
|-------------------|------------------------|-----------------------------|-----------------|---|
| C789 | | | 1,2,3,4 | See F 314 |
| | | | 5. | COMPLETION DATE = 12-16-2013 |
| C790 | | | 1,2,3,4 | See F323 |
| | | | 5. | COMPLETION DATE = 12-16-2013 |
| C797 | | | 1,2,3,4 | See F281 |
| | | | 5. | COMPLETION DATE = 12-16-2013 |
| C798 | | | 1,2,3,4 | See F329 |
| | | | 5. | COMPLETION DATE = 12-16-2013 |
| C835 | | | 1, 2, 3, 4, | See F176. |
| | | | 5. | COMPLETION DATE =12-16-2013 |



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
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December 5, 2013

Michael G. Andrus, Administrator
Franklin County Transitional Care
44 North First East
Preston, ID 83263-1326

Provider #: 135059

Dear Mr. Andrus:

On **November 22, 2013**, a Complaint Investigation survey was conducted at Franklin County Transitional Care. Bradley Perry, L.S.W. and Lauren Hoard, R.N. conducted the complaint investigation. The complaint was investigated in conjunction with the facility's annual Recertification and State Licensure survey conducted on November 18-22, 2013.

The following documents were reviewed:

- Cleaning schedules for the visitors' restrooms; and
- Temperature logs of the washing machine for clothes.

The following observations were conducted:

- The visitors' restrooms were observed multiple times during the survey;
- Linens, blankets and quilts were observed in nine residents' rooms; and
- Two top loading washers were observed.

The following interviews were conducted:

- During the group interview, nine residents were interviewed;
- One housekeeper, the Director of Housekeeping and the Head of the Laundry Department were interviewed; and
- The Idaho Ombudsman from Area V with the Agency on Aging was interviewed.

Michael G. Andrus, Administrator
December 5, 2013
Page 2 of 3

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00006065

ALLEGATION #1:

The complainant stated the visitor's restroom to the left side of the entrance door of the facility is terrible.

FINDINGS:

Observations of the two visitors' restrooms were found to be clean throughout the survey. Housekeeping staff were observed cleaning the restrooms. The Idaho Ombudsman had no concerns with the restrooms and she stated she uses the women's restroom during each quarterly visit. A housekeeper and the Director of Housekeeping were interviewed regarding the cleaning schedules of the restrooms, and both stated the restrooms are cleaned at least daily and had documentation as evidence.

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

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The complainant stated linens are not being laundered adequately with residential style top loading washing machines.

FINDINGS:

Linens, blankets and quilts in the rooms of nine residents were observed to be clean and appropriately laundered. Two top loading washing machines were observed to be working correctly. Temperature logs were reviewed and found to be within federal regulation standards.

The Idaho Ombudsman was interviewed regarding the cleanliness of residents' linens and blankets and she stated that on her quarterly visits she has not found unclean bedding. The Head of the Laundry Department was interviewed regarding the laundry issue, and she stated prior to April 1, 2013, the facility had a contract with an outside vendor who laundered their linens and bedding; however, the linens would sometimes come back with stains and would have to be sent

Michael G. Andrus, Administrator
December 5, 2013
Page 3 of 3

them back to be laundered again. She also said the facility did not renew the contract and started cleaning linens in house. They have had no issues since that time. She stated that the facility is in the process of replacing the washers with a commercial washer within the next few months. When asked about how residents' large blankets or quilts are washed, she stated they only wash one at a time in order to get them clean.

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

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, slightly slanted style.

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

LKK/dmj