IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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

December 8, 2014

Rene Stephens, Administrator
Clear Creek Home
1411 Falls Avenue East, Suite 703
Twin Falls, ID 83301

RE: Clear Creek Home, Provider #13G074

Dear Ms. Stephens:

This is to advise you of the findings of the Medicaid/Licensure survey of Clear Creek Home, which was conducted on December 4, 2014.

Enclosed is a Statement of Deficiencies/Plan of Correction Form CMS-2567, listing Medicaid deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner:**

1. What corrective action(s) will be accomplished for those individuals found to have been affected by the deficient practice;

2. How you will identify other individuals 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 in place or what systemic change you will make to ensure that the deficient practice does not recur;

4. 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;

5. The plan must include the title of the person responsible for implementing the acceptable plan of correction; and

6. Include dates when corrective action(s) will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions, which require construction, competitive bidding or other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **December 21, 2014,** and keep a copy for your records.

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 the State Informal Dispute Resolution (IDR) Process which can be found on the Internet at:

www.icfmr.dhw.idaho.gov

Scroll down until the Program Information heading on the right side is visible and there are three IDR selections to choose from.

This request must be received by December 21, 2014. If a request for informal dispute resolution is received after December 21, 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 our visit. If you have questions, please call this office at (208) 334-6626, option 4.

Sincerely,

Michael A Case, LSW

MICHAEL CASE
Health Facility Surveyor
Non-Long Term Care

Nicole Wisenor

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

MC/pmt
Enclosures

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

PRINTED: 12/08/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	13G074		12/04/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEAR CREEK HOME	797 CASWELL WEST TWIN FALLS, ID 83301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS The following deficiencies were cited during the recertification survey conducted from 12/1/14 - 12/4/14. The survey was conducted by: Michael Case, LSW, QIDP Common abbreviations used in this report are: DCS - Direct Care Staff IPP - Individual Program Plan LPN - Licensed Practical Nurse RN - Registered Nurse	W 000		
W 322	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure individuals were provided with general and preventative medical care for 1 of 5 individuals (Individual #5) whose medical records were reviewed. This resulted in an individual not receiving appropriate monitoring and care of her G-tube. The findings include: 1. Individual #5's 8/19/14 IPP stated she was a 12 year old female whose diagnoses included profound mental retardation. She utilized a G-tube (gastrostomy tube, a small tube inserted through the abdomen into the stomach) for nutrition and medication administration.	W 322	RECEIVED FEB - 3 2015 FACILITY STANDARDS	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Rene Stephens | TITLE: Administrator | (X6) DATE: 12/19/14

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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W 322	Continued From page 1 The facility's Incident Reports were reviewed from 5/1/14 - 12/1/14 and included the following: - 5/27/14 at 8:50 a.m.: DCS A documented she was told by a co-worker that Individual #5's "g tube balloon" was out. DCS A documented "I put it back in." - 7/14/14 at 8:10 a.m.: DCS A documented Individual #5's g-tube had fallen out. The documentation stated DCS A replaced the tube and re-inflated the balloon. During an observation on 12/2/14 from 6:30 - 8:00 a.m., DCS A was observed to assist Individual #5 with her morning medications utilizing the G-tube. DCS A was not observed to check for residuals or to check for placement of the G-tube prior to administering medications. When asked during the observation, DCS A stated the LPN had trained her to provide G-tube care, including how to replace the tube if it came out. DCS A stated she did not know about checking residuals or how to check for placement as the G-tube could only go into one place. When asked about replacing the tube when it came out, DCS A stated she had been trained to lubricate the tube, re-insert it, and inflate the balloon with 5 cc's of water. DCS A stated the tube would come out periodically, and stated she also removed the tube once a month to cleaned it, then reinserted it to ensure the balloon still contained 5 cc's of water. Individual #5's protocol for "Dislodgement of G-tube," revised October 2014, was reviewed. The protocol did not include directions for	W 322	**W322** Corrective training will be implemented to proficiently teach the established standard by the RN for the client in question. We have received physician instructions that greatly clarify specifics that were of concern during the survey. Delegation forms will be completed and signed by the RN indicating the competence is established as well as the names of staff authorized to perform these duties. A review of all files in this home and client for other homes will assess that all delegated tasks are correctly delegated and corresponding documentation is in place to support the RN. All clients identified with medical care plans requiring delegation of nursing care services will be reviewed and delegation forms will be completed by the RN and LPN listing specific staff at the specific locations. A review of the nursing file structure at least quarterly by QIDP, RN, and LPN will validate the services requiring delegation and provide said delegation documentation and training. Date of Correction: 01-15-2015 Responsible: QIDP, LPN, RN	

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W 322	Continued From page 2 checking placement of the G-tube once it was reinserted. Additionally, the protocol included information about deflating the balloon and re-inflating with 5 cc's of water once monthly to ensure proper inflation, but did not include directions to remove and clean the tube. During an interview on 12/2/14 from 3:45 - 4:03 p.m., the RN stated she did not know direct care staff were replacing Individual #5's G-tube when it became dislodged. The RN stated she had always gone in to complete the task when she was on-call, and assumed the LPN was the one replacing the G-tube at other times. The RN stated the G-tube should be checked for placement anytime it was replaced and before use. The RN stated the LPN had completed training with the staff. The RN stated she had not observed staff or completed written delegations related to Individual #5's G-tube. During an interview on 12/4/14 from 9:00 - 10:15 a.m., the LPN stated she had trained staff to reinsert the tube if it came out, but had not trained staff to check for placement. The LPN stated staff were to deflate the balloon and re-inflate it with 5 cc's of water once a month, but were not supposed to be removing and cleaning the tube. Both the LPN stated staff were not trained to check for residuals as Individual #5's physician had not required them. The LPN and RN, who was present during the interview, stated Individual #5's G-tube protocol and staff training needed to be revised. The facility failed to ensure Individual #5 received appropriate care related to her G-tube. Note: On 12/4/14 at 10:20 a.m., the LPN provided	W 322		

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W 322	Continued From page 3 an Office Visit note, dated 12/5/11, which stated "Her [G-tube] will be vented and no residuals will be checked."	W 322		
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure nursing services were provided as needed for 1 of 5 individuals (Individual #5) whose medical records were reviewed. This resulted in an individuals not receiving adequate intervention necessary to meet her health needs. The findings include: 1. Refer to W322 as it relates to the facility's failure to ensure an individual received health care services in accordance with her needs.	W 331	**W331** See W322 Date of Correction: 1-15-2015 Responsible: QIDP, LPN, RN	
W 336	483.460(c)(3)(iii) NURSING SERVICES Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure nursing reviews were completed on a quarterly basis for 3 of 4 individuals (Individuals #1, #3 and #4) whose medical records were reviewed. This resulted in the potential for medical problems to	W 336		

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W 336	Continued From page 4 not be identified in a timely fashion. The findings include: 1. Individuals #1, #3 and #4's medical records were reviewed. The records included nursing reviews that were completed on 12/31/13, 3/21/14, 7/28/14, and 10/30/14. The medical records did not include a completed review for the second quarter (April, May, June) of 2014. During an interview on 12/4/14 from 9:00 - 10:15 a.m., the LPN said the quarterly nursing reviews for the second quarter of 2014 were rescheduled and completed on 7/28/14. The LPN stated a makeup review had not taken place. The facility failed to ensure nursing reviews were completed on a quarterly basis.	W 336	**W336** Quarterly nursing reviews have been updated to ensure that that they are met within the established time frames, specifically, within each quarter. A file review during survey noted that the quarterly review had been delayed by 30 days, missing one quarter even though the corresponding schedule of assessments established actually included 4 total reviews for the year. LPN and RN have scheduled corresponding assessments to align within the correct time frames for the regulatory guidelines. Any adjustments will be noted by LPN and RN and dates will be established from that point forward to keep the reviews within the quarter as required. Reminders have been revised to send out each quarter, February, May, August, and November. If a scheduled review must be changed there is still adequate time to be sure it happens in a timely manner. Date of Correction: 1-15-2015 Responsible: LPN, RN	
W 345	483.460(d)(3) NURSING STAFF The facility must utilize registered nurses as appropriate and required by State law to perform the health services specified in this section. This STANDARD is not met as evidenced by: Based on review of Board of Nursing Rules and Regulations, observation, record review and staff interviews, it was determined the facility failed to ensure their registered nurse was utilized as per this standard and as required by state law. This directly impacted 1 of 5 individuals (Individual #5) whose medical records were reviewed, and had the potential to impact all individuals (Individuals #1 - #8) residing at the facility. This resulted in the potential for individuals to experience negative impacts to their health. The findings include:	W 345		

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W 345	Continued From page 5 1. The Idaho Board of Nursing Rules and Regulations (IDAPA 23.01.01) state at IDAPA 23.01.01.401.02.(f) that the RN is responsible to maintain "safe and effective nursing care..." by "Acting as a patient's advocate" (as stated in IDAPA 23.01.01.401.02.(f.)(iii) and by collaborating with other health professionals (as stated in IDAPA 23.01.01.401.02.h). IDAPA 23.01.01.401 states that in addition to providing hands on care, licensed Registered Nurses are responsible for "delegation, management, administration, teaching and case management...[and]...are expected to exercise competency in judgment, decision making, implementation of nursing interventions, delegation of function or responsibilities, and administering of medications and treatments prescribed by legally authorized persons." IDAPA 23.01.01.400.02 states "When delegating nursing care, the licensed nurse retains accountability for the delegated acts and the consequences of delegation." Additionally, IDAPA 23.01.01.400.02.c stated the licensed nurse must "Exercise professional judgment to determine the safety of the delegated activities, to whom the acts may be delegated, and the potential for harm." IDAPA 23.01.01.400.03.(a) states that subsequent to delegation the licensed nurse shall "Evaluate the patient's response and the outcome of the delegated act, and take such further actions as necessary..." and IDAPA 23.01.01.400.03.(b) states that subsequent to delegation, the licensed nurse shall "Determine the degree of supervision required and evaluate	W 345	**W345** See W331 and W322 Date of Correction: 1-15-2015 Responsible: LPN, RN	

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W 345	Continued From page 6 whether the activity is completed in a manner that meets acceptable outcomes. The degree of supervision shall be based upon...the knowledge and competence of the individual to whom the activity is delegated." During an interview on 12/2/14 from 3:45 - 4:03 p.m., the RN stated she had not provided any written delegation of nursing tasks. The RN stated the LPN provided training to unlicensed assistive personnel (direct care staff), and that she (the RN) completed quarterly physical assessments and chart reviews to provide oversight. However, Individual #5's record did not document the oversight and monitoring provided by the RN was sufficient to ensure the individual's needs were appropriately met. Refer to W331 as it relates to the RN's failure to provide sufficient monitoring and oversight to ensure an individual received nursing services in accordance with her needs.	W 345		

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NAME OF PROVIDER OR SUPPLIER: CLEAR CREEK HOME

STREET ADDRESS, CITY, STATE, ZIP CODE: 797 CASWELL WEST, TWIN FALLS, ID 83301

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M 000	16.03.11 Initial Comments The following deficiencies were cited during the licensure survey conducted from 12/1/14 - 12/4/14. The survey was conducted by: Michael Case, LSW; QIDP	M 000		
			MM735 – see W322	
MM735	16.03.11.270.02 Health Services The facility must provide a mechanism which assures that each resident's health problems are brought to the attention of a licensed nurse or physician and that evaluation and follow-up occurs relative to these problems. In addition, services which assure that prescribed and planned health services, medications and diets are made available to each resident as ordered must be provided as follows: This Rule is not met as evidenced by: Refer to W322.	MM735		
			MM760 – see W331, W345 and W322	
MM760	16.03.11.270.03 Nursing Services Residents must be provided with nursing services in accordance with their needs. There must be a responsible staff member on duty at all times who is immediately accessible, to whom residents can report injuries, symptoms of illness, and emergencies. The nurse's duties and services include: This Rule is not met as evidenced by: Refer to W331 and W345.	MM760		
			MM766 – see W336	
MM766	16.03.11.270.03(c)(iii) Periodic Reevaluation The periodic reevaluation of the type, extent, and quality of services and programming; and	MM766		

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FEB - 3 2015
FACILITY STANDARDS

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Rene Stephens | TITLE: Administrator | (X6) DATE: 12/19/14

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MM766	Continued From page 1 This Rule is not met as evidenced by: Refer to W336.	MM766		