



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 24, 2014

Steve E. Lish, Administrator
Discovery Care Center
600 Shanafelt Street
Salmon, ID 83467-4261

FILE COPY

Provider #: 135129

Dear Mr. Lish:

On **December 5, 2014**, a Recertification and State Licensure survey was conducted at Discovery Care Center by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be an isolated deficiency that constitutes actual harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

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

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **January 6, 2015**. Failure to submit an acceptable PoC by **January 6, 2015**, may result in the imposition of civil monetary penalties by **January 26, 2015**.

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

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

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

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

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

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

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

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **June 5, 2015**, if substantial compliance is not achieved by that time.

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

Steve E. Lish, Administrator
December 24, 2014
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Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

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

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

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

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

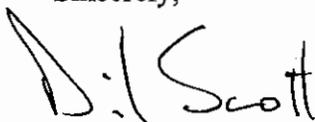
- BFS Letters (06/30/11)

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

This request must be received by **January 6, 2015**. If your request for informal dispute resolution is received after **January 6, 2015**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,



DAVID SCOTT, R.N., Supervisor
Long Term Care

DS/dmj
Enclosures

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

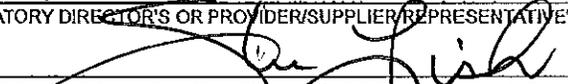
PRINTED: 12/24/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135129	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/05/2014
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NAME OF PROVIDER OR SUPPLIER DISCOVERY CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 600 SHANAFELT STREET SALMON, ID 83487
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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)	(X6) COMPLETION DATE
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F 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the annual Federal recertification survey of your facility. The survey team entered the facility on December 1, 2014 and exited the building on December 5, 2014.</p> <p>The surveyors conducting the survey were:</p> <p>Nina Sanderson, LSW, BSW - Team Coordinator Amy Barkley, RN, BSN</p> <p>Survey definitions were:</p> <p>ADL = Activities of Daily Living ADON = Assistant Director of Nursing CAA = Care Area Assessment CNA = Certified Nursing Assistant DON/DNS = Director of Nursing LN = Licensed Nurse MDS = Minimum Data Set MS = Multiple Sclerosis</p> <p>F 226 SS=E 483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Based on policy review and staff interview, it was determined the facility failed to develop a policy and procedure to protect residents during the investigative process following an allegation of</p>	F 000	<p>"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Discovery Care Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."</p> <p>Corrective Actions: No resident was identified for F226. Identification of others affected and corrective actions: An audit was done of any allegation of abuse or neglect within 90 days of present survey. Measures to ensure that the deficient practice does not happen again: The facility developed an abuse and neglect policy. All staff educated on policy as of 1/2/15.</p>	
	<p>RECEIVED FEB - 9 2015 FACILITY STANDARDS</p>	F 226		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Executive Director	(X6) DATE 02/05/15
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

* Revision to revised 01/19/15 POC

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F 226	<p>Continued From page 1</p> <p>abuse or neglect. The deficient practice had the potential to impact any resident who made an allegation of abuse or neglect, and had the potential for harm if the resident was not protected from the accused throughout the investigation. Findings included:</p> <p>Review of the facility's Resident Abuse Prohibition Policy, dated 12/7/10 documented, under the section for the protection of residents while an abuse investigation is being conducted, "...The Charge Nurse will take whatever actions necessary to ensure the resident's safety while the investigation is in process. This may include temporary suspension of staff or assigned suspecting [sic] staff to work only while under the direct observation of another staff..."</p> <p>On 12/2/14 at 11:55 AM, the Administrator stated if the facility received an allegation of abuse or neglect involving a staff member, the employee would be immediately suspended until the investigation was complete. The Administrator identified the DNS as the facility's abuse coordinator.</p> <p>On 12/4/14 at 4:30 PM, the DNS stated, "If I had cause to believe the allegation was true, then I would suspend the employee. Then I would conduct an investigation." When asked how she would determine whether or not there was cause to believe an allegation was true before the investigation was conducted, the DNS stated, "It would depend on what we know about the history of the resident and the staff person involved. I wouldn't want to accuse someone wrongly. For instance, if it's the first allegation I've received regarding a particular employee, I would separate them from the resident until I figured out if the</p>	F 226	<p>Monitor corrective actions: DNS will review all abuse or neglect allegations 1 x week for 4 weeks for compliance to the policy. The audit results will be brought to QA monthly for 3 months. Audits to begin 12/30/14 Corrective Actions will be completed</p>	1/5/15

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F 226	Continued From page 2 allegation could be real." When asked, the DNS stated the Administrator would be notified, "If I feel it is a serious enough allegation - serious enough that I feel it may have been abuse." When asked how other residents were protected from abuse from the accused staff member until the facility had determined the allegation was "real," the DNS did not respond. The DNS stated the facility had not had an allegation of abuse or neglect for more than a year, so she would need to review the policy to answer any further questions regarding the investigative process or resident protection.	F 226			
F 248 SS=E	On 12/4/14 at 6:45 PM, the Administrator, DNS, and ADON were informed of these findings. The facility offered no further information. 483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, individual and group resident interviews, staff interview, and record review, it was determined the facility failed to provide a meaningful activities program designed to meet the interests and needs of the resident population. This was true for 7 of 7 residents in the resident group, as well as 3 of 10 (#'s 4, 5 and 9) sampled residents. The deficient practice had the potential for harm if residents experienced	F 248	Corrective Actions: The corrective actions for residents #4, #5 and #9 that were affected by the alleged deficient practice was to involve them in the restructuring of the new activities calendar on 1/2/2015. The facility has interviewed all current SNF residents or family for input/feedback to determine satisfaction of activities being offered. Based on interviews and assessments, the residents Care Plans will be updated to reflect each resident's preference. Identification of others affected and corrective actions: Other residents were identified through interviews of all current SNF residents.		

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F 248	<p>Continued From page 3</p> <p>mood changes resulting from boredom. Findings included:</p> <p>1. On 12/2/14 at 10:15 AM during the Resident Group Interview, the residents stated the facility's activities program did not meet their leisure needs. The residents stated bingo games were offered six days per week. Four of the seven residents present stated that was too much bingo. The other three stated they attended just to have something to do, but did not really care for bingo. Five of the seven stated they did not have enough to do in the afternoons or evenings. One of the residents stated she had spoken to the activities director, with suggestions of things she would enjoy, but had not received feedback. The residents stated they felt the frequency of bingo was offered to accommodate the residents from the facility's assisted living center, since they frequently attended the bingo games.</p> <p>2. Resident #5 was admitted to the facility in March of 2013 with a diagnosis of multiple sclerosis (MS). The resident was later diagnosed with colon cancer and opted not to seek treatment for that condition.</p> <p>Resident #5's Annual MDS, dated 3/20/14, coded a total mood severity score of 3 (minimal depression). On 9/12/14, her Quarterly MDS assessment coded a score of 9 (minimal depression). Both assessments coded the resident was cognitively intact.</p> <p>Resident #5's activities care plan documented a focus, revised on 3/17/14, that the resident was reluctant to attend social groups and self-isolated. Interventions included consulting family about the resident's new interests and needs, taking the</p>	F 248	<p>Measures to ensure that the deficient practice does not happen again:</p> <p>The Activities Director has been educated about involving all SNF residents during activity planning.</p> <p>Activities are now an agenda item during the monthly SNF resident council meetings for residents to provide ongoing input/feedback. Discussion will also include resident feedback regarding the current month's scheduled activities and to provide input for the upcoming month's activity's calendar. Additionally, a minimum of 25% of SNF residents, who do not attend resident council, will be individually interviewed for their input/feedback regarding activities. The information will be used to assist with planning activities. The Administrator will ensure that the Activities Director/Designee has full time hours, per week, for sufficient time dedicated to meet the facility's SNF activity's program needs.</p>	

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F 248	<p>Continued From page 4</p> <p>resident outside weather permitting, and that it was important for the resident to have access to the television. The care plan was consistent with the documentation on the resident's most recent Activity Quarterly Evaluation dated 9/17/14.</p> <p>On 12/2/14 at 8:40 AM, Resident #5 was observed to propel herself in her wheelchair from the dining room to her room, and turn her television on. The resident continued to watch television for the next 2 hours. The resident was observed in her room at 2:15 PM, in the same position in front of her television, dozing. She was observed in this position, until 5:00 PM, intermittently awake, dozing, and watching television. At 5:00 PM, when asked, the resident stated, "There's never anything to do here. I wait all day for the Cartwrights (the television program Bonanza) and they just came on."</p> <p>3. Resident #4 was admitted to the facility on 6/20/14 following a left above the knee amputation, and re-admitted in November following a right above the knee amputation.</p> <p>Resident #4's initial MDS, dated 7/8/14, coded it was very important for her to have access to books and animals. The corresponding CAA, from the same date, documented no input from the resident regarding this area. Resident #4's most recent quarterly MDS assessment, dated 10/1/14, coded she was cognitively intact.</p> <p>The resident's activities care plan, most recently revised on 10/16/14, did not document any interventions which included animals.</p> <p>On 12/2/14 at 3:30 PM, during a resident interview, Resident #4 became tearful, stating</p>	F 248	<p>Monitor corrective actions:</p> <p>The measures implemented will be monitored by the Executive Director/Designee via weekly meetings with the Activity Director x 2 months to ensure compliance.</p> <p>Effectiveness will be reported monthly through the QA process and all concerns will be addressed with the Administrator.</p>	2/5/2015	

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F 248	<p>Continued From page 5</p> <p>she and her husband had bred and shown dogs for more than 40 years, and she missed that aspect of her life greatly. When asked, the resident stated she and her husband had a dog which now lived in a kennel, although she was not sure how much longer that arrangement could be sustained. [Please see F 250 for details]. The resident stated she would like more interactions with dogs.</p> <p>4. Resident #9 was admitted to the facility on 6/6/13. Her diagnoses included lumbago, anxiety and mild progressive dementia.</p> <p>Resident #9's most recent quarterly MDS, dated 9/12/14, coded the resident had moderately impaired cognition, and a mood severity score of 11, indicating moderate depression.</p> <p>The resident's activities care plan, initiated on 10/4/13, documented the resident had little or no interest in activity involvement. The interventions documented the resident liked Mother's Day Tea, and family took her out to eat monthly (dated 10/4/13). Additionally, she enjoyed family visits, pet visits, reading, watching television, live music, shopping, and crafts.</p> <p>On 12/2/14, during the resident group interview, the resident stated she "hated bingo," but went due to lack of other choices.</p> <p>On 12/3/14 at 4:05 PM, during a resident interview, Resident #9 stated she was, "Bored stiff." The resident gestured by tightening her upper body, pulling her elbows against her ribs, closing her eyes, grimacing, clenching her fists, and stating, "Grrrrrrr." The resident stated she spent a lot of time reading, and went to bingo</p>	F 248			

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F 248	<p>Continued From page 6</p> <p>when it was offered. However, the resident stated, "I hate bingo, but it's all there is to do. I have no quality of life." The resident identified she had feelings of anxiety related to her boredom.</p> <p>5. The facility's activities calendar documented bingo games on Mondays, Wednesdays, and Saturdays at 3:00 PM, and "Poker Bingo" on Fridays at 10:45 AM. Additionally, there was an unspecified "Game Time" on Thursdays at 3:00 PM, which the resident group stated was usually a bingo game of some sort.</p> <p>On 12/2/14 at 2:30 PM, the facility's Activities Calendar documented a crafting activity. At 2:40 PM here was only one person observed in attendance. The person identified herself as a resident from the facility's assisted living section.</p> <p>On 12/3/14 at 3:15 PM, ten residents were observed playing bingo. RN #2 stated six of those residents were from the facility's assisted living area, and four from the skilled nursing section.</p> <p>6. On 12/3/14 at 9:25 AM, the Activities Director (AD) stated her time was split between serving as the facility's Activities Director and Social Services Designee. The AD stated she had been taking the residents to the local Senior Center, but was told she could no longer do that because the center could not accommodate residents in wheelchairs. The AD was not certain how long ago this had taken place, but in the future she was planning to replace that outing with a "donut run" to the local grocery store. The AD stated she thought there were usually 15 participants in the facility's bingo games, about half of which were from the assisted living section of the facility. The AD stated she had sought input from the facility</p>	F 248			

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F 248	<p>Continued From page 7</p> <p>residents via the resident council, although council attendance was sporadic. Additionally, at present, there was not an active president of the resident council. The AD stated she also went room-to-room, and felt the residents were satisfied with the activities program. The AD had no response when informed of the concerns from the resident group meeting.</p> <p>On 12/3/14 at 10:30 AM, the Administrator stated the amount of bingo on the activities calendar was per resident request. She stated the facility received complaints in the past when bingo had not taken place or changes were made to the activity calendar. When questioned further, the Administrator stated many of those complaints were from residents in the assisted living section of the facility. The Administrator stated the skilled nursing residents had opted not to have a structured Resident Council group. As a result there had been a great deal of inconsistency in resident attendance, and it had been difficult to ascertain how they felt about the activities program overall. The Administrator stated resident interests changed as the clientele changed, which would normally be discussed in resident council. The Administrator stated he would talk to the AD to make sure the activities program was focused on the wishes of the nursing facility residents.</p> <p>On 12/4/14 at 11:15 AM, the survey team made an attempt to interview the AD. The AD stated she was on her way to conduct an activity in the assisted living portion of the facility, and would check back later. At 11:30 AM, the AD returned for the interview. The AD stated her duties were to serve as the AD and SSD for the skilled nursing facility, and that she was responsible to</p>	F 248		

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F 248	Continued From page 8 "organize" the activities for assisted living. The AD clarified she had developed the activity calendar for the assisted living residents, arranged for special events, and trained staff how to carry out the activities on the schedule. When asked if she worked for the skilled nursing facility, the assisted living, or both, the AD stated, "That would be a good question for the Administrator." When asked how much of her weekly time was devoted to each of her roles, the AD stated, "That would be a good question for the Administrator." On 12/4/14 at 11:40 AM, the Administrator stated the AD's budgeted hours, and additional staff hours, for each position were based on census in each area of the facility. The Administrator stated the activities for the skilled nursing facility had a completely separate budget, in terms of personnel and supplies, from assisted living. On 12/4/14 at 6:45 PM, the Administrator, DNS, and ADON were informed of these findings. The facility offered no further information.	F 248			
F 250 SS=G	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and record review it was determined the facility failed to recognize continued and	F 250	Corrective Actions: The corrective actions for residents #4, #5, #6 and #9 was to notify the MD. For resident #4, a Licensed Social Worker (LSW) has assessed and continues to address current residents' concerns. The LSW referred resident #4 to Lemhi Valley Social Services. Residents #4, #5, #6 and #9 have had their Health Care Plan individually updated and has visited with the Licensed Social Worker, as of 1/16/2015		

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F 250	<p>Continued From page 9</p> <p>worsening signs of depression; develop and implement resident-specific care plans to address signs and symptoms of depression; and ensure safety notifications were made to qualified professionals to rule out suicidal ideation, intent, or plan. The facility also failed to identify key psychosocial issues and identify support systems to help residents resolve them. This was true for 4 of 9 (#s 4, 5, 6, and 9) sampled residents.</p> <p>*Resident #5 sustained psychosocial harm when she experienced a pattern of feelings of being "better off dead," which continued to be present at the time of survey, without notification or assessment to a qualified professional and without development of a care plan to address these feelings;</p> <p>*Resident #9 was harmed when she expressed ongoing depression and began to verbalize feelings she would be "better off dead," which continued at the time of survey, without notification or safety assessment from a qualified professional;</p> <p>*Resident #4 had the potential for harm when the facility failed to identify concerns the resident was having with the health status changes which precipitated her skilled nursing placement, and the impact of those changes on her situation in the community; and</p> <p>*Resident #6 had the potential for harm when he expressed feelings of being "better off dead" without notification to a qualified professional to rule out suicidal ideation or intent.</p> <p>Findings included:</p> <p>Federal guidance in the State Operations Manual, Appendix P - Survey Protocol for Long Term Care Facilities Psychosocial Outcome Severity Guide documented, "Severity Level 3 Considerations: Actual Harm...Persistent depressed mood that</p>	F 250		

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F 250	<p>Continued From page 10</p> <p>may be manifested by verbal and nonverbal symptoms such as: Social withdrawal; irritability; anxiety, hopelessness; tearfulness; crying...Loss of interest or ability to experience or feel pleasure nearly every day for much of the day...Expressions of feelings of worthlessness or excessive guilt nearly every day...Recurrent thoughts of death (not just fear of dying) or statements without an intent to act (e.g., "I wish I were dead")..."</p> <p>The facility provided a policy and procedure for "Suicide Precautions" however, the policy did not address a clear delineation of what should be done, when, and by whom suicidal ideation and intent should be managed. The policy only addressed what should happen if a resident expressed a suicide plan.</p> <p>The facility utilized a Social Services Designee for the provision of social services in the facility. The employee filling that role at the time the survey took place had completed some, but not all, of the state's required training program for a Social Services Designee (SSD). The facility did not document referrals to mental health or social services professionals for any of the identified residents. See interviews below.</p> <p>1. Resident #5 was admitted to the facility in March of 2013 with a diagnosis of multiple sclerosis (MS). The resident was later diagnosed with colon cancer, and opted not to seek treatment for that condition.</p> <p>Resident #5's 3/20/14 Annual MDS assessment coded the resident was cognitively intact. Her overall mood severity score was a 3 (minimal depression); however, she answered in the</p>	F 250	<p>Measures to ensure that the deficient practice does not happen again:</p> <p>On 1/16/2015 the LSW reviewed residents who were identified with depression and/or other psychosocial needs providing interventions as needed. Should for any reason the facility experienced the lack of an LSW, those services will be provided by a sister facility until another LSW can be hired or contracted with. This individual will be in the facility at minimum once per month. Social Services and MDS Coordinator have been educated on the need to update the MD and address any resident that triggered for depression or psychosocial needs on their MDS.</p> <p>Identification of others affected and corrective actions:</p> <p>Any resident could have been affected. The facility has hired a Licensed Social Worker. The Licensed Social Worker has reviewed and assessed all resident's last quarterly assessments for follow-up and referral as needed by 01/16/2015.</p>	

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F 250	<p>Continued From page 11</p> <p>affirmative that she had had thoughts she would be better off dead or of hurting herself nearly half of the days in the previous two weeks. The affirmative response triggered a follow up Safety Notification question on the MDS of, "Was responsible staff or provider informed that there is a potential for resident self-harm?" This question was answered, "yes." It was not clear from the response which staff or provider should be, or was, notified of a safety concern with the resident.</p> <p>Resident #5's CAA Worksheets, dated 3/20/14, documented a "triggering condition" for the Mood State area due to the resident's response to the self-harm question on the MDS. The Resident Input area of the CAA documented, "Res[ident] does verbalize frustrations as needed to staff...declines antidepressant." The CAA indicated a care plan would be developed, as "Res[ident] is very candid living with MS is not ideal and will verbalize frustrations as needed...does come out for meals...and chooses not to participate in activities in the facility." The CAA did not document an analysis of the resident's statement regarding the potential for self-harm, nor whether any safety notification had been made.</p> <p>On 3/21/14, a Social Services Annual Evaluation for Resident #5 documented, "...alert and oriented. She is very self-conscious [sic] of her limitations and prefers to be alone...She spends most of her time in her room...does not like having a roommate and whenever she gets one she complains about small things...She eats adequately although she states she only does so because she knows she needs to not because she desires to do so..."</p>	F 250	<p>Monitor corrective actions:</p> <p>Monitoring will be done by the DNS/Designee per the MDS schedule for residents that have triggered for depression. 1 x week for 1 month, and then monthly x 3 months, to ensure that the MD has been notified, interventions in place and IDT is involved.</p> <p>Effectiveness will be reported monthly through the QA process and all concerns will be addressed with the Administrator.</p>	02/02/2015	

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F 250	Continued From page 12 Resident #5's care plan did not document a focus area specific to the resident's mood state, nor regarding any feelings she may have regarding harming herself. There was a focus area documented for, "Potential for a psychosocial well-being problem [related to] social isolation due to her issues with her MS," dated 3/26/14. The interventions included allowing the resident time to verbalize her feelings, the resident's preference to remain in her room, and to "increase communication" between the resident, staff, and the resident's family about the resident's living environment. It was not clear how this last intervention was to be implemented. There was no documentation on the resident's care plan regarding her potential for self-harm, or her wish to be dead. There was no guidance for the staff as to how to proceed in the event these indicators should occur. Review of Resident #5's interdisciplinary Progress Notes (PNs) between 3/10/14 and 3/31/14 revealed no social services entries. There was no documentation regarding the resident's mood state or "increased communication" in the nursing entries. On 4/8/14, a physician's progress note for Resident #5 documented, "Subjective...The patient has some anger regarding her diagnosis and some depression. She has not been interested in activities that previously she found enjoyable and pleasurable." There was no documentation under the Assessment or Plan as to how severe this depression was, or a plan to address the depression. On 6/11/14, a nursing PN documented,	F 250			

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F 250	<p>Continued From page 13</p> <p>"Res[ident] saw [physician] today and was notified that she has colorectal cancer, locally advanced...recommended that res[ident] see oncologist for [chemotherapy and radiation]..."</p> <p>On 6/16/14 at 5:24 PM, a Social Services PN documented, "... She has felt down, depressed, and hopeless nearly every day, stating all three. [Resident #5] said I know I would be better off dead and feels this way nearly everyday [sic]. She said she would never harm herself..." The PN was signed by the facility's Activities Director, who also served as the Social Services Designee. There was no documentation as to whether the resident's new diagnosis of colorectal cancer, and treatment recommendations for chemotherapy and radiation, had been assessed and ruled out as contributing factors to her mood state.</p> <p>Resident # 5's quarterly MDS, dated 6/17/14, coded she was cognitively intact. Her overall mood score was a 6, indicating mild depression. This mood score represented an increase from the previous score. The resident reported feeling down, depressed, or hopeless daily; and that she had daily thoughts that she would be better off dead or hurting herself in some way. The Safety Notification question was answered in the affirmative, although there was no documentation this was carried out. No mood state care plan was initiated for the resident.</p> <p>On 6/18/14, a Social Services Quarterly Evaluation documented the resident preferred to be in her room and to watch TV, did not participate in groups, and felt she could not do things due to her MS diagnosis. There was no documentation which evaluated the resident's response to her new diagnosis of cancer.</p>	F 250			

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F 250	<p>Continued From page 14</p> <p>On 6/23/14, a nursing PN documented the resident had returned from seeing the gastroenterologist, with no new orders. On that same date, the resident's care plan was updated to include that the resident had a rectal mass, but had opted for no further treatment. There were no updates documented on the resident's psychosocial well-being care plan.</p> <p>On 8/12/14, a physician's progress note documented, "Patient has no new acute complaints or concerns. Staff has noted ongoing withdrawal from activities she was previously positive about and noted for. She really would like to be left to herself on these issues..." The assessment and plan was documented as, "...will continue to encourage to socialize and provide supportive care."</p> <p>The resident's 9/12/14 quarterly MDS assessment coded the resident was cognitively intact. Her overall mood severity score was a 9, indicating mild depression. However, the MDS coded the resident had felt decreased pleasure or interest in doing things more than half of the days in the past two weeks. The MDS also coded the resident felt down, depressed, or hopeless daily and had daily thoughts she would be better off dead or of harming herself. Additionally, the resident chose not to respond to the inquiry of whether she felt badly about herself or if she had let her family down, which she had previously answered in the negative. The MDS documented a Safety Notification had been made, but no documentation regarding this notification was present.</p> <p>No mood state or psychosocial well-being care</p>	F 250			

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F 250	<p>Continued From page 15</p> <p>plan updates were documented following the 9/12/14 MDS, despite an increase in the resident's total mood severity score. This was the second consecutive MDS which coded an increase in the resident's total mood severity score.</p> <p>On 9/12/14 at 5:07 PM, a Social Services PN documented, "...also feels she would be better off dead nearly every day but would not hurt herself." There was no documentation from either the nursing staff nor the resident's physician regarding the resident's mood state.</p> <p>A 9/18/14 Social Services Quarterly Assessment did not contain documentation regarding the resident's mood state.</p> <p>On 10/14/14, a physician's progress note documented, "No new concerns from this resident. No new nursing concerns."</p> <p>On 12/3/14 at 3:00 PM, during a resident interview, the resident stated, "I wish I was dead. And I mean that. This is no way to live. And I'm tired of hearing that I should be happy to be alive or grateful to be alive. That's baloney." The resident stated she had been encouraged to attend religious services at the facility, and "of desperation" she tried to attend but, "That's not for me. I've never been religious and I'm not going to start now." When asked if she had ever been offered counseling services, the resident stated, "I don't need therapy to make me want to be alive. I want therapy to help me cope." The resident did not verbalize an active suicide plan, but stated, "Maybe you could push me outside in the snow and leave me there."</p>	F 250			

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F 250	<p>Continued From page 16</p> <p>On 12/4/14 at 11:40 AM, when asked, the SSD, with the Administrator present, stated the DNS was notified of the resident responding in the affirmative to the question regarding being better off dead or thoughts of harming herself. The SSD did not know what the DNS did once given the information. When asked, the SSD said she did not think the resident would harm herself, stating, "she says she would be better off dead but would never hurt herself." When asked, the SSD stated she had not had training regarding assessing a resident for suicidal ideation, intent, or plan, beyond what she had received from the state health care association. The Administrator stated the SSD had completed the first portion of a state required 2-part course, but the second had not yet been offered since the SSD accepted her current position. When asked, the Administrator stated the facility's consultant licensed social worker had quit without notice several months prior, as had several subsequent social workers. The Administrator stated the facility recently entered into a new contract with another social worker, but that person had not been consulted on this resident. The Administrator stated the nearest formalized mental health services were provided in a city several hours' drive from the facility. The Administrator stated he would need to research to determine if the resident's physician had been informed of the results of the mood interviews. When asked, the Administrator and SSD both stated the staff would not respond to the resident by telling her she should be grateful or happy to be alive, in light of her circumstance. However, neither was able to state what interventions the staff should use to respond to the resident when her statements were made.</p> <p>On 12/4/14 at 1:15 PM, the DNS stated she</p>	F 250			

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F 250	<p>Continued From page 17</p> <p>recalled the SSD telling her about the resident's MDS results, but did not document that notification. The DNS stated, "I know she [the resident] wasn't suicidal." When asked how the resident's state of mind had been assessed, the DNS stated, "I point blank asked her." The DNS stated she did not have additional training, beyond being an RN, regarding mental health issues, including suicide. The DNS stated she did not feel the resident had been continually depressed throughout the entire time from the 3/30/14 MDS until the 9/12/14 MDS as, "The MDS is only a snapshot in time. It doesn't tell you how the person is really doing." However, the DNS was not able to explain what the facility had done to alleviate the resident's expressions of despair, the increase in the types and frequency of depressive responses on the MDSs, nor why the resident continued to express those feelings and frustration with the facility's interventions during the surveyor's interview with the resident.</p> <p>Resident #5 was harmed when she experienced feelings of distress and despair, to the point where she consistently felt she would be better off dead. During this time she also began to withdraw from pleasurable activities she previously enjoyed, all the while experiencing continued progression in her MS as well as receiving a new diagnosis of colon cancer. While there was documentation of the existence of these indicators by the facility, there was no documentation the resident received a consultation from a qualified social services or mental health professional to assess her state of mind, and develop a treatment plan to meet her individualized psychosocial needs rather than cause her additional frustration. While the physician did document periodically on an</p>	F 250			

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F 250	<p>Continued From page 18</p> <p>awareness of the deterioration in the resident's mood state, there was no documented assessment of that deterioration or plan to address those feelings. Additionally, it was not clear the physician was made aware of the resident's mood state severity scores per her answers on her MDS, including her feelings of being better off dead or hurting herself in some way.</p> <p>On 12/4/14 at 6:45 PM, the Administrator, DNS, ADON, and SSD were informed of these findings. On 12/8/14, a fax was received by the Bureau of Facility Standards with additional information. However, this information did not resolve the concerns.</p> <p>2. On 12/2/14 at 10:15 AM, during the resident group interview, Resident #9 requested a private interview with the surveyors to discuss some concerns. On 12/3/14 at 4:05 PM, the surveyor met with the resident. The resident asked for assistance to, "Get me out of here." Amongst the resident's concerns were, "My quality of life. There is nobody here I can go to and talk to. The girls are nice, but they can't give you the right advice." The resident, who had been lying across her bed, sat up at the edge of her bed, tightened her upper body, drew her elbows tightly against her rib cage, closed her eyes and grimaced, and stated forcefully, "I'm bored stfff!" [Please see F 248 for details]. When asked, the resident stated she experienced anxiety. The resident stated, "It just feels so fullle. Nothing gets done...I'm just angry." The resident requested assistance in looking into her concerns. The survey investigation revealed:</p> <p>Resident #9 was admitted to the facility on 6/6/13.</p>	F 250			

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F 250	<p>Continued From page 19</p> <p>Her diagnoses included lumbago, anxiety and mild progressive dementia.</p> <p>The resident's care plan documented focus areas of, "Potential for mood problem [related to] anxiety [manifested by] negative comments about others," and, "...at risk for depression [manifested by] episodes tearfulness will verbalize that she is depressed," beginning 10/4/13. The focus areas were documented as revised on 10/16/14 and 11/14/14 respectively, although it was not clear from the documentation how the focus areas had been revised. Interventions included the administration of her anti-anxiety medication Buspar (initiated 10/4/13, revised 11/14/14), and allow time for the resident to verbalize her feelings (initiated 10/4/13, revised 6/21/14). There was also an intervention, initiated 10/4/13, which documented, "Encourage [Resident #9] to set realistic goals. Encourage participation from resident who depends on others to make decisions."</p> <p>Resident #9's Quarterly MDS, dated 3/20/14, documented the resident had moderately impaired cognition. Her overall mood severity score was 2, indicating minimal depression. The MDS coded the resident had experienced both little interest or pleasure in doing things; and feeling down, depressed, or hopeless several days out of the previous two weeks. The resident's care plan documented the resident was receiving 10 mg of Celexa per day at the time this MDS was completed.</p> <p>On 4/29/14, Resident #9's care plan documented her Celexa was discontinued due to a successful gradual dosage reduction attempt.</p>	F 250			

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NAME OF PROVIDER OR SUPPLIER DISCOVERY CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 600 SHANAFELT STREET SALMON, ID 83467		
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F 250	<p>Continued From page 20</p> <p>Resident #9's Annual MDS, dated 6/16/14, documented she had moderately impaired cognition. Her overall mood severity score had increased to an 8, indicating mild depression. The MDS coded the resident had experienced little interest or pleasure in doing things and feeling down, depressed, or hopeless daily; and feeling tired or having little energy half or more of the days in the previous 2 weeks. These findings were also documented in a social services progress note from that date. Additionally, the progress note documented, "She stated, 'I just want to go home.'...[Resident #9] has been spending more time in her room and reading. She was in good spirits." It was unclear how the determination had been made the resident was in "good spirits" at the same time she reported multiple indicators of depression, and was noted to spend more time alone in her room. The CAAs for the 6/16/14 MDS triggered several care areas to be further evaluated for care plan development, including cognitive loss; communication, psychosocial well-being, mood state, and activities. The area of the CAA for resident or family input in each of these areas, was blank. Please see F 279 for details.</p> <p>There was no documentation the physician was consulted regarding the resident's statements in light of the discontinuation of her anti-depressant medication less than two months prior to this assessment.</p> <p>On 6/21/14, two of the existing interventions for Resident #9's mood state care plan were revised. It could not be determined what the interventions had been before the revisions. However, the updated interventions documented, "Allow [Resident #9] to answer and verbalize her</p>	F 250			

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F 250	<p>Continued From page 21</p> <p>feelings, perceptions, fears. [Resident #9] has episodes of forgetfulness, confusion, and may need repeated cues and time to verbalize issues," and, "Allow [Resident #9] to share feelings over lost riles to [sic] life on assisted living and changes in functional mobility."</p> <p>On 8/12/14, a physician's progress note for Resident #9 documented, "Patient has done well with her depression..."</p> <p>On 8/28/14, Resident #9's care plan documented the resident was restarted on Celexa 10 mg daily, "after [Resident #9] complaints [sic] of being depressed for past couple months." The resident's physician's orders also documented the resident was started on Buspar 10 mg per day on the same date. It could not be determined why or how the physician determined the resident was doing "well" with her depression on 8/12/14, then re-started her anti-depressant medication and added an anti-anxiety medication just 16 days later due to complaints of depression going back a "couple months."</p> <p>Resident #9's Quarterly MDS, dated 9/12/14, documented the resident had moderately impaired cognition. The resident's overall mood severity score had increased to an 11, indicating moderate depression. The MDS coded the resident had felt down, depressed, or hopeless daily; and had been tired with decreased energy, feeling badly about herself, and thoughts of being better off dead or of harming herself more than half the days in the past two weeks. The MDS coded a Safety Notification had been made due to the resident's affirmative response to the question for the potential of self-harm for the resident, however no documentation of such a</p>	F 250			

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F 250	Continued From page 22 notification was found. On 9/12/14 at 10:09 AM, a nursing progress note documented, "...Res[ident] receives Buspar 10 mg daily [diagnoses anxiety]; Celexa 10 mg daily [diagnosis depression] recently restarted [related to] complaints of depression..." at 4:59 PM, a social services progress note documented, "... [Resident #9] also feels she would be better off dead 7-11 of the days over the previous two weeks, but would not hurt herself..." On 9/19/14 at 6:45 PM, a care conference progress note documented a meeting with the facility staff, the resident, and her family member. The note documented, "...Discussed restarting the Celexa [due to] the resident expressing that she 'felt depressed'..." The entry was made by the DNS. On 12/4/14 at 2:40 PM, the DNS initially stated the care conference was conducted by another nurse, so she could not speak to the content of the progress note. When asked why she would write a note for another nurse's work, the DNS stated, "Oh, well, I was present at the meeting." When asked about the answers coded on the resident's MDS in conjunction with the care conference, the DNS stated, "At the time of the care conference, she wasn't depressed, she said she was fine. Plus, per the behavior monitor, we know she wasn't depressed." The DNS could not explain why she had documented the resident expressed feelings of depression during the conference, if the resident had actually stated she was "fine." Additionally, the DNS's statements did not resolve the surveyor's concern regarding the MDS coding of increased depression, the resident's report of feelings of depression in a care conference 7 days later, and the resident's statements to the surveyor during the interview	F 250			

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F 250	<p>Continued From page 23 the previous day.</p> <p>Resident #9's Behavior Monthly Flow Sheet for September 2014, which documented target behaviors of anger, tearfulness, and degrading others; was blank. For October 2014, 5 episodes of anger were documented for evening shift for each 10/9/14, 10/10/14, and 10/13/14.</p> <p>On 10/14/14, the resident's care plan documented the resident's Celexa was decreased to 10 mg every other day. It could not be determined why the resident's Celexa was decreased in dosage when the resident had complained of increased depression within the past month, nor when target behaviors had been noted 3 times within the past week.</p> <p>The November 2014 Behavior Monthly Flow Sheet was blank.</p> <p>Resident #9 was harmed when she reported, and demonstrated, a continued deterioration in her mood state and quality of life, to the point where the resident felt she would be "better off dead" per her most recent MDS assessment. While the facility had documentation of these indicators, medically related social services were not provided to ensure the resident had the opportunity to achieve her highest practicable emotional and psychosocial well-being.</p> <p>On 12/4/14 at 6:45 PM, the Administrator, DNS and ADON were informed of these findings. On 12/8/14 the facility faxed additional information, which did not resolve the concerns.</p> <p>3. Resident #4 was admitted to the facility on 6/20/14 following a left above the knee</p>	F 250			

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F 250	<p>Continued From page 24</p> <p>amputation, and re-admitted in November following a right above the knee amputation.</p> <p>Resident #4's most recent quarterly MDS assessment, dated 10/1/14, coded she was cognitively intact; had little interest or pleasure in doing things several days out of the previous two weeks; felt down, depressed, or hopeless more than half the days; was tired with little energy several days; and had appetite changes several days.</p> <p>On 12/2/14 at 3:30 PM, during a resident interview, the resident became tearful. She stated she had come to the facility initially after she had her leg amputated, and was working hard with therapy towards a goal of returning home when the determination was made she had to have the second leg amputated. The resident stated while this was unfolding, her husband had cardiac issues which required him to be transported to a hospital several hours away for an extended period of time to become stabilized. The resident stated in addition to concern for her husband, she had concern for the couple's dog, which was "just like a child to us." The resident stated she arranged for the dog to be placed in a local kennel on a "temporary basis," but that was in July and the dog was still there. The resident stated, "Now I have to stay here, which is expensive, and my husband has had to move to assisted living, which is also expensive. I don't know how much longer we can afford to board the dog, and they called me last week to tell me the dog was depressed and not eating. I'm not ready to place him up for adoption, but I don't know if they will let my husband keep him in assisted living." The resident stated she was looking into Medicaid assistance, but "It's so</p>	F 250			

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F 250	<p>Continued From page 25</p> <p>complicated it's exhausting." The resident stated she hoped to get a specialized wheelchair which may give her enough independence either to return home or move to assisted living with her husband. However, the resident reported that she had to travel to a "specialist" in a community in a neighboring state several hours away to get authorization from her insurance company to cover the cost of the wheelchair. The journey would require travel over a "fairly treacherous" mountain pass. The resident stated, "I know my husband wants to drive me, but he just can't drive that pass safely. I'm trying to figure out another ride, but I haven't had any luck." When asked if the facility had someone who was working with her to resolve her multiple concerns, the resident stated, "The physical therapist is trying to help me get the wheelchair, but otherwise I didn't even know there was someone here who could help me figure it out."</p> <p>On 12/3/14 at 8:15 AM, the Administrator stated he helped the resident access an elder law attorney to assist her with the process of applying for Medicaid. The Administrator stated the facility was aware the resident needed to have an assessment for the specialized wheelchair, but had to be realistic about crossing the pass in the winter months. The Administrator stated, "We need to make sure it's safe." The Administrator was aware the resident's dog was in a kennel, but was unaware of the resident's level of attachment to the dog, or that the cost of keeping the dog in the kennel was wearing on the resident. The Administrator stated, "You know, it's a tough situation. Because of the condition of the home, we all knew her husband could not go back there. I helped get him into the assisted living. I really feel for them." The Administrator stated perhaps</p>	F 250			

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F 250	<p>Continued From page 26</p> <p>the SSD had done additional work to help the resident and her husband resolve the rest of their concerns.</p> <p>On 12/3/14 at 9:26 AM, when asked, the SSD stated, "I visit frequently with her [Resident #4] and assure her she will return to normal soon, listen to her feelings, and validate her feelings." When asked if the SSD felt assuring the resident she would return to "normal" was realistic in light of her recent double amputation, the SSD stated, "Well I was thinking more of activities like knitting."</p> <p>On 12/3/14 at 10:30 AM, the Administrator reported he had checked the weather report, and tentatively scheduled transportation for the resident to be assessed for her wheelchair the following week.</p> <p>On 12/4/14 at 6:45 PM, the Administrator, DNS, ADON, and SSD were informed of these findings. The facility offered no further information.</p> <p>4. Resident #6 was admitted to the facility on 9/27/12 and re-admitted on 5/3/14 with multiple diagnoses which included leg amputation, Type II diabetes, and depression.</p> <p>Section D of the MDS related to Mood was reviewed for 3/21/14, 5/9/14, 8/7/14, and 11/7/14. Each assessment documented the resident answered, "Yes" to having, "Thoughts that you would be better off dead, or of hurting yourself in some way." Additionally, the MDS documented, "Yes," the Responsible staff or provider [was] informed that there is potential for resident self</p>	F 250		

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F 250	<p>Continued From page 27 harm.</p> <p>The current care plan indicated Resident #6 had depression manifested by tearfulness. Care plan interventions, dated 8/13/13, documented, "[Resident #6 needed assistance/encouragement/support to identify problems that could not be controlled and provide opportunities for resident's family to participate in care; 3/26/14, Zoloft 50 mg every other day; 10/26/14, observe for side effects of anti-depressant medication..."</p> <p>The Social Service Notes reviewed from 3/1/14 through 12/4/14 did not document follow-up had occurred with the responsible staff and/or provider when the resident had verbalized thoughts of being better off dead or of hurting himself in some way, during the above identified assessments.</p> <p>On 12/4/14 at 11:40 AM, when asked, the SSD and the Administrator stated the DNS would have been the responsible staff member notified of the resident's MDS results.</p> <p>On 12/4/14 at 1:15 PM, the DNS stated she had been informed of the resident's mood issues, and had assessed the resident was not at risk of hurting himself. The DNS stated she had no specialized mental health training beyond what she received as part of her RN education. The DNS could not identify a diagnostic tool which had been used to rule out suicidal ideation or intent for this resident. The DNS stated she did not document her interaction with the resident when determining he was not at risk of harming himself.</p>	F 250			

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F 250	Continued From page 28 On 12/4/14 at 6:45 PM the Administrator, DNS, ADON, and SSD were notified of these issues. On 12/8/14 the additional information was received via fax by the Bureau of Facility Standards, however, this information did not resolve the concerns.	F 250			
F 252 SS=E	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observation and group interview, it was determined the facility did not ensure the dining room was comfortable and decorated in a homelike manner. This was true for 6 of 7 residents attending group and any resident eating in the dining room. The deficient practice had the potential to cause more than minimal psychosocial harm when the dining room was furnished with items not to their liking. Findings included: On 12/1/14, 12/2/14, and 12/3/14, black tablecloths with black napkins were observed on the dining room tables. On 12/2/14 at 10:15 AM, residents attending the group interview were asked if the facility was decorated and furnished to their liking to promote a homelike environment. Anonymous Resident #11 said the tables in the dining room were	F 252	Corrective Actions: Regarding the anonymous residents #11, 12, and 13, the dietary manager has visited with eight random residents, after the removal from use of the black tablecloths/napkins to obtain and document their comments/concerns. Identification of others affected and corrective actions: All residents that eat in the dining room could have been affected. Measures to ensure that the deficient practice does not happen again: Licensed Social worker or designee will ask for resident input about dining room colors during monthly Resident Council Meeting to determine if the dining room decorations are to the majority of residents liking. Monitor corrective actions: Social services will audit resident response to dining room decorations each month, for 3 months in Resident Council meeting and bring the results to QA monthly. Audits to begin 1/2/15 Corrective Actions will be completed	1/16/15	

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F 252	Continued From page 29 always covered with black tablecloths during meals. Anonymous Resident #11 stated, "When we see the tablecloths we wonder who died." Anonymous Resident #12 stated, "The black table clothes are disgusting," and she did not understand why the facility had decided to use black. Anonymous Resident #13 stated, "The black table clothes are dreary and depressing," and said she did not enjoy eating in the dining room. On 12/3/14 at 10:30 AM, the Administrator and Dietary Manager (DM) were informed of the identified concern. The DM said she was unaware that residents did not like the black tablecloths. The DM stated she thought there were green tablecloths available and would look for them. On 12/3/14 at 5:30 PM, green tablecloths were observed on the tables. No further information was provided related to the concern.	F 252			
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and	F 279			

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F 279	<p>Continued From page 30</p> <p>psychosocial well-being as required under §483.26; and any services that would otherwise be required under §483.26 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility did not ensure Care Area Assessments (CAA's) included input from the resident and/or family/representative regarding the care areas. This affected 7 of 9 (#s 1-6 & 9) sampled residents. This failed practice created the potential for more than minimal harm if residents' needs were not met due to lack of input from the resident or family member. Findings included:</p> <p>1. Resident #2 was admitted to the facility on 10/24/14 with multiple diagnoses which included Congestive Heart Failure (CHF), acute kidney failure, and Leukocytosis.</p> <p>Resident #2's Care Area Assessment or CAA's, dated 11/6/14, triggered care plan considerations for cognitive loss, communication, ADL function, urinary incontinence, psychosocial well-being, activities, falls, nutritional status, dental care, pressure ulcer, and pain. In each of these categories, the area of the CAA, input from the resident and/or family/representative regarding the care area was blank or did not include sufficient information.</p> <p>2. Resident #3 was admitted to the facility on 6/27/11 with multiple diagnoses which included</p>	F 279			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135129	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/05/2014
NAME OF PROVIDER OR SUPPLIER DISCOVERY CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 600 SHANAFELT STREET SALMON, ID 83467		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 279	<p>Continued From page 31 edema, chronic pain, depression, and cognitive impairment.</p> <p>Resident #3's CAA's, dated 5/30/14, triggered care plan considerations for cognitive loss/dementia, visual function, communication, ADL function, urinary incontinence, psychosocial well-being, behavioral symptoms, falls, nutritional status, dehydration/fluid maintenance, dental care, pressure ulcer, psychotropic drug use, and pain. In each of these categories, the area of the CAA for input from the resident and/or family/representative regarding the care area was blank or did not include sufficient information.</p> <p>3. Resident #6 was admitted to the facility on 9/27/12 and re-admitted on 5/3/14 with multiple diagnoses which included leg amputation, Type II diabetes, and depression.</p> <p>Resident #6's CAAs, dated 5/15/14, triggered care plan considerations for delirium, cognitive loss/dementia, communication, ADL function, urinary incontinence, psychosocial well-being, activities, falls, nutritional status, pressure ulcer, psychotropic drug use, and physical restraints. In each of these categories the area of the CAA for input from the resident and/or family/representative regarding the care area was blank or did not include sufficient information.</p> <p>4. Resident #1's CAAs, dated 5/22/14, triggered care plan considerations for cognitive loss/dementia, visual function, communication, urinary incontinence, behavioral symptoms, falls, nutritional status, pressure ulcer, and psychotropic drug use. In each of these categories, the area of the CAA for input from the resident and/or family/representative regarding</p>	F 279	<p>Corrective Actions: Res # 1-6 and 9 were contacted and/or the family/representative, to allow them to provide any input regarding the resident's plan of care. This will be placed in a progress note as of 01/09/15.</p> <p>Identification of others affected and corrective actions: Any residents with CAA assessment could have been affected.</p> <p>Measures to ensure that the deficient practice does not happen again: Social Services will continue to schedule a care plan meeting, as per the MDS schedule, with the resident/family/representative to ensure their involvement in the care planning process. The MDS Nurse or designee will correspondingly verify that the CAA section, regarding resident/family/representative participation is completed every comprehensive MDS.</p>		

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F 279	Continued From page 32 the care area was blank or did not include sufficient informallon. 5. Residents #4, 5, and 9 had similar findings related to the lack of resident and/or family input related to care areas identified on the CAAs. On 12/4/14 at 4:55 PM, the DNS and SSD were notified related to the above concern. The DNS stated, "They are not that way now." The DNS confirmed prior to her completing the CAAs the resident and/or family input had not been obtained and offered no explanation. When asked how the resident's voice was brought forward into the care plan, the DNS said, "Typically we have done that in a progress note." She said the facility is now filling out the CAAs so the resident has a voice and if a concern is identified the facility can document it on the CAA.	F 279	Monitor corrective actions: DNS or designee will audit all comprehensive assessments for 3 months for resident/family/representative input on triggered CAA. The audit results will be brought to QA monthly. Audits to begin 1/5/15. Corrective Actions will be completed	1/16/15
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview, and record review, it was determined the facility did not ensure care plans were followed for assistance and adaptive equipment during meals; failed to ensure a foot cradle was	F 309	Corrective Actions: The corrective actions for residents #1, #3 and #5's individual care plans were reviewed for appropriateness and follow through as of 1/2/2015. Resident #1's care plan has since been updated, again, to utilize briefs at nighttime for modesty and comfort. Resident #3's care plan has since been updated, again, to utilize briefs at nighttime. Identification of others affected and corrective actions: All residents care planned could have been affected. The DNS/Designee will validate staff following the individualized care plans for appropriateness and any changes made as needed.	

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F 309	<p>Continued From page 33</p> <p>used in bed; did not consistently offer fluids during cares; and did not assess the appropriateness of leaving a resident open to air while in bed. This was true for 3 of 10 (#s 1, 3, & 5) sampled residents reviewed during the survey. This practice had the potential to cause more than minimal harm when interventions were not consistently implemented for a resident needing assistance and adaptive equipment during meals; a clear reason was not identified for leaving a resident with dementia open to air; a foot cradle was not used and fluids not offered as care planned; and a resident was observed with foot pedals when her care plan specified they were not to be used. Findings included:</p> <p>1. Resident #3 was admitted to the facility on 5/27/11 with multiple diagnoses which included edema, chronic pain, depression, and cognitive impairment.</p> <p>The Quarterly MDS, dated 11/21/14, documented the resident required extensive assistance of one person for meals.</p> <p>The current care plan indicated Resident #3 had self-care deficit related to limited range of motion in her upper extremities and poor vision. The care interventions, dated 11/12/14, documented, "Resident #3 is easily distracted and has very poor eyesight, cues as to what is on her plate and where, set-up assist, and verbal and tactile cues to stay on task." Additionally, the care plan identified the resident was to use sippy cups with straws.</p> <p>On 12/2/14 at 12:40 PM, the resident was observed sitting at the dining room table. A CNA delivered the resident's lunch, however the CNA</p>	F 309	<p>Measures to ensure that the deficient practice does not happen again:</p> <p>The nursing staff has been educated on the importance of maintaining interventions as listed on the care plans. Systematic changes include the IDT will review care plans with the MDS schedules and the clinical meeting, during business hours, where the status of resident changes will be reviewed and care plans updated as needed. In addition, as Care Plans are initially created or updated the information will carry over to the CNA's "Point of Care" for their access. The practice of "open-to-air" has been discontinued. Incontinence products will be used when residents are in bed.</p> <p>Monitor corrective actions:</p> <p>Monitoring will be done by the DNS/Designee 1 x week for 1 month, and then monthly x 3 months, to ensure that care plans have been updated to the needs of the residents. The DNS/Designee will perform rounds and document results to validate individualized plans of care are being followed accordingly.</p> <p>Effectiveness will be reported monthly through the QA process and all concerns will be addressed with the Administrator.</p> <p>Corrective Actions will be completed</p>	02/13/2015	

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NAME OF PROVIDER OR SUPPLIER DISCOVERY CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 600 SHANAFELT STREET SALMON, ID 83467		
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F 309	<p>Continued From page 34</p> <p>did not inform the resident what was on her plate or where each item was before walking away. Additionally, the resident's fluids were in regular cups and not in sippy cups with straws as directed by the resident's care plan. At 12:53 PM, LN #1 sat down with the resident and handed the resident a glass of water. The LN then got up, moved her chair between Resident #3 and the resident's tablemate, sat with her back to Resident #3 and assisted the tablemate to eat. At 12:55 PM, LN #1 turned towards Resident #3, gave her a bite of food and told the resident, "Use your fork." The LN did not cue the resident to what was on her plate, where each item was located, or provide verbal/tactile cues to the resident.</p> <p>On 12/2/14 at 4:56 PM, the resident was observed sitting at the dining room table, where she was brought a glass of water and a supplement. At 5:05 PM, CNA #3 without explanation to the resident, removed the resident's supplement from the table, filled the glass with milk and replaced it in front of the resident. At 5:15 PM, CNA #3 delivered the resident's meal, cut up the meat, placed a piece of meat on the resident's fork, and walked away from the table. The CNA did not cue the resident related what was on her plate, where each item was located, or provide verbal/tactile cues to the resident. Between 5:15 PM and 5:25 PM, the resident's food sat untouched on the resident's plate. At 5:25 PM, CNA #4 sat beside the resident and asked the resident how she was doing, placed a piece of meat on the resident's fork and then walked away from the resident. The CNA did not cue the resident related what was on her plate, where each item was located, or provide verbal/tactile cues to the resident. At 5:35 PM, LN</p>	F 309			

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F 309	<p>Continued From page 35</p> <p>#2 walked over to the resident and offered the resident a bite of food and then walked away. The LN did not provide any cues to the resident.</p> <p>On 12/3/14 at 10:30 AM, the Administrator, DNS, and Dietary Manager were informed of the above concern. The Dietary Manager stated she had sippy cups with straws available for the resident to use, however she was unaware the resident was supposed to use them. The DNS confirmed the resident's care plan identified the resident was to use sippy cups with lids. No further information was provided related to staff not following the care plan for the resident during meals.</p> <p>2. Resident #1 was admitted to the facility in July 2010 with multiple diagnoses which included Alzheimer's disease.</p> <p>Resident #1's most recent quarterly MDS, dated 11/19/14, coded severely Impaired decision making skills; physical behaviors towards others daily; dependence on 2 persons for transfers, dressing, and toileting; and incontinent of bowel and bladder.</p> <p>a. Resident #1's ADL care plan, dated 8/9/13, documented an intervention of, "[Resident #1] is very modest; keep her covered as much as possible during cares. She doesn't like to get chilled, provide a warm blanket as needed," revised on 10/2/14. These same interventions were documented on her care plan for a behavior problem of combativeness with staff, revised on 10/23/13, as well as an intervention to warm periwipes before use.</p>	F 309			

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F 309	<p>Continued From page 36</p> <p>Resident #1's current care plan for potential for pressure ulcer development, revised on 11/6/14, documented an intervention of the resident being left open to air while in bed, dated 4/26/14.</p> <p>On 12/2/14 at 8:50 AM, CNA #4 and CNA #5 were observed providing cares to Resident #1. CNA #5 opened a new pack of periwipes to use during cares. They had not been warmed. When the cares were completed, the resident was placed in bed, nuda from the waist down, and covered with a blanket.</p> <p>On 12/4/14 at 1:20 PM, the DNS stated the resident's care plan intervention of "open to air" meant the staff were to leave her nude from the waist down when she was in bed, and cover her with a blanket. The DNS stated this intervention kept the resident's skin dry, "like you would do with a baby," to prevent skin breakdown. The DNS was asked, but was unable to provide, a facility policy and procedure for leaving residents open to air as a preventive measure for skin breakdown, or any clinical research which documented this was an effective approach. Further, the DNS stated the resident tended to become combative with staff when being dressed and undressed. The facility had identified, when this happened, covering the resident with a warm blanket had been determined inconsistent in its effectiveness. The DNS was unable to explain how the practice of leaving her open to air had been assessed and monitored as an appropriate intervention for this resident, in light of her Alzheimer's diagnosis and behavioral concerns. When asked how the open to air intervention was consistent with the resident's documented preferences for warmth and modestly, the DNS stated, "That's what the blanket is for. So she is</p>	F 309		

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F 309	<p>Continued From page 37 warm and covered up."</p> <p>b. Resident #1's 11/16/13 care plan documented an intervention of offering fluids during cares. During care observations on 12/2/14 at 8:50 AM, and 12/9/14 at 3:00 PM, fluids were not offered to the resident.</p> <p>The resident's 7/9/14 care plan for potential for skin breakdown documented interventions of a foot cradle in place. The foot cradle was not observed in place on 12/2/14 at 8:50 AM, 9:50 AM, and 2:15 PM; and on 12/3/14 between 2:45 and 3:15 PM.</p> <p>The DNS was informed of these observations on 12/4/14 at 1:20 PM.</p> <p>On 12/4/14 at 6:45 PM, the Administrator, DNS, and ADON were informed of these findings. The facility offered no further information.</p> <p>3. Resident #5 was admitted to the facility in March 2013 with a diagnosis of MS.</p> <p>Resident #5's ADL care plan documented an intervention of, "...uses wheelchair for mobility...prefers not to use foot pedals."</p> <p>On 12/1/14 at 3:00 PM, Resident #5 was observed sitting in her room in her wheelchair. Foot pedals were attached to her wheelchair which contradicted the ADL intervention. Each pedal included a black padded trough-shaped enclosure in which her feet rested. These devices were observed in place on 12/2/14 between 8:00 and 9:50 AM, 12:40 PM, and 5:25 PM. On 12/3/14 at 3:00 PM, the resident was interviewed in her room. The foot pedals and troughs were in</p>	F 309		

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F 309	Continued From page 38 place. The resident stated they were there because she fell out of bed, and she did not like them or understand why they were being used. On 12/4/14 at 1:15 PM, the DNS stated the foot pedals were not placed due to a fall, but due to "foot drag" from her MS. The DNS stated the resident had originally agreed to wear them, and was unaware the resident was now objecting to their use. The DNS stated she would talk to the resident again, then make sure the care being provided matched the resident's care plan. On 12/4/14 at 6:45 PM the Administrator, DNS, and ADON were informed of these findings. The facility offered no further information.	F 309			
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to	F 441			

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F 441	<p>Continued From page 39</p> <p>prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on policy review and staff interview, it was determined the facility did not maintain records regarding staff illnesses, and therefore did not have information to determine if corrective actions were needed. The deficient practice could impact any resident exposed to illnesses spreading amongst employees, and had the potential to cause harm if residents became ill. Findings included:</p> <p>The facility's Infection Control Policy and Procedure regarding employee infections, dated May 2007, documented any employee having an infection was to report that infection to the infection control nurse. The policy documented the infection control nurse would complete and maintain an employee infection record whenever these reports were made.</p>	F 441			

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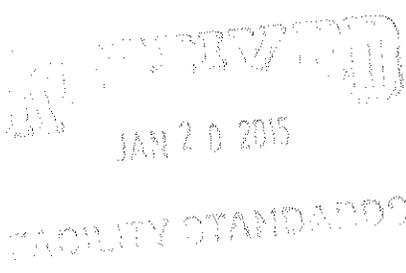
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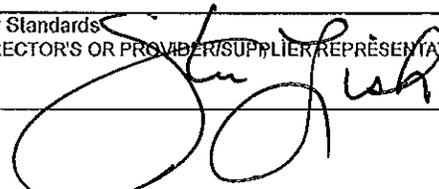
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F 441	<p>Continued From page 40</p> <p>On 12/4/14 at 3:35 PM, the facility's Infection Control (IC) Nurse stated she was not informed when employees called in sick, nor what their symptoms were. The IC Nurse stated she did not maintain employee infection records or track whether infections were spreading from employee to employee, or from employee to resident.</p> <p>On 12/4/14 at 6:45 PM, the Administrator, DNS, and ADON were informed of these findings. The Administrator stated the IC Nurse was new to the position, and had not yet been trained as to that aspect of the job. The Administrator stated the facility would ensure this training was completed, and tracking initiated. The facility offered no further information.</p>	F 441	<p>Corrective Actions: A binder has been set up to monitor staff infections.</p> <p>Identification of others affected and corrective actions: All residents in the facility could have been affected.</p> <p>Measures to ensure that the deficient practice does not happen again: Education will be provided to licensed staff on the need to track staff infections 12/10/14. The infection control nurse will include staff infections in the monthly trending for analysis and intervention.</p> <p>Monitor corrective actions: DNS or designee will conduct an audit 1 x month for 3 months to validate staff infections have been included in the infection control process. The audit results will be brought to QA monthly for 3 months. Audits to begin 01/02/15.</p> <p>Corrective Actions will be completed</p>	1/5/15	

Bureau of Facility Standards

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C 000	16.03.02 INITIAL COMMENTS The following deficiencies were cited during the annual State Licensure survey for your facility. The survey team members were: Nina Sanderson, LSW, BSW - Team Coordinator Amy Barkley, RN, BSN	C 000		
C 361	02.108,07 Housekeeping Services and Equipment 07. Housekeeping Services and Equipment. Sufficient housekeeping and maintenance personnel and equipment shall be provided to maintain the interior and exterior of the facility in a safe, clean, orderly and attractive manner. This Rule is not met as evidenced by: Please refer to F 252 as it relates to attractive environment.	C 361	C361 Please refer to F252	
C 422	02.120,05,p,vii Capacity Requirments for Toilets/Bath Areas vii. On each patient/resident floor or nursing unit there shall be at least one (1) tub or shower for every twelve (12) licensed beds; one (1) toilet for every eight (8) licensed beds; and one (1) lavatory with mirror for every eight (8) licensed beds. Tubs, showers, and lavatories shall be connected to hot and cold running water. This Rule is not met as evidenced by: Based on observation and staff interviews, it was determined the facility failed to maintain the	C 422		

Bureau of Facility Standards
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE:  TITLE: Executive Director (X5) DATE: 01/19/2015

* revision to original poc submitted 1/5/2015.

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001170	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/05/2014
NAME OF PROVIDER OR SUPPLIER DISCOVERY CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 600 SHANAFELT STREET SALMON, ID 83467		
(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 422	<p>Continued From page 1</p> <p>minimum number of bathing facilities for the number of licensed beds. This affected 9 of 10 (#s 1-9) sampled residents and had the potential to affect all residents who reside in the facility. Findings included:</p> <p>The facility was licensed for 45 certified beds. At the beginning of the survey process, 28 residents resided in the facility.</p> <p>On 12/4/14 at 11:00 AM, during the General Observations of the Facility with the Maintenance Supervisor, the Bathing Room was observed with two bathtubs and one shower stall. However, one bathtub was covered with plywood particle board, numerous articles were on top of the board over the bathtub, and numerous pieces of equipment were stored in the area where the bathtub was located, blocking access to the bathtub. There was plumbing projecting from the wall above the bathtub, however there was no shower head attached to the plumbing.</p> <p>The Maintenance Supervisor stated, "There is only one bathing room and none of the individual resident rooms have a tub or a shower." The surveyor and the MS reviewed the requirement of one tub or shower for every 12 certified beds. Forty-five (45) certified beds divided by 12 equaled 3.75.</p> <p>On 12/4/14 at 11:30 AM, the surveyor informed the Administrator of the finding. The Administrator said, "Yes. We had a waiver last year, and will need one again this year."</p> <p>On 12/4/14 at 6:45 PM, the Administrator, DON, and ADON were informed of the finding. The facility did not provide any additional information.</p>	C 422	C422 Requesting Waiver for number of bath/shower facilities 01/02/15.	

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C 664	Continued From page 2	C 664		
C 664	<p>02.150,02,a Required Members of Committee</p> <p>a. Include the facility medical director, administrator, pharmacist, dietary services supervisor, director of nursing services, housekeeping services representative, and maintenance services representative. This Rule is not met as evidenced by: Based on policy review, staff interview and review of the facility's Infection Control meeting minutes, it was determined the facility did not ensure the required persons attended the Infection Control committee meeting at least quarterly. The deficient practice had the potential to affect any resident in the facility, and to cause harm if the facility failed to identify an infection trend, and implement measures of correction. Findings included:</p> <p>The facility's Infection Control Committee policy documented the committee included nursing, dietary, pharmacy, environmental services, employee health, quality assurance, and the infection control practitioner. The policy did not stipulate the medical director would attend the meetings, but instead documented the medical staff "vested" the committee with the authority to institute appropriate infection control measures.</p> <p>On 12/4/14 at 3:35 PM, when asked for documentation of all state required participants in attendance at quarterly Infection Control meetings, the Infection Control Nurse stated she was new to the role and would have to check.</p> <p>On 12/4/14 at 4:45 PM, the Administrator stated the Infection Control Committee met in conjunction with the facility's QA committee, and</p>	C 664	<p>C664 Corrective Actions: The Pharmacist and MD have been educated on 01/13/15, regarding the requirement to attend the infection control committee portion of the QA committee meeting on 01/20/15 and, at minimum, participate on a quarterly basis thereafter. Identification of others affected and corrective actions: All residents that are reviewed in the infection control meeting could have been affected. The ED will validate compliance of the MD and Pharmacist's required participation. Measures to ensure that the deficient practice does not happen again: Infection control meetings will be coordinated with the MD and Pharmacist's schedules, in advance, for purposes of ascertaining their participation on, at minimum, a quarterly basis. Monitor corrective actions: DNS or designee will conduct an audit for required attendee's signature 1x month for 3 months for QA/Infection control meetings. The audit results will be brought to QA monthly. Audits to begin 01/20/15. Corrective Actions will be completed</p>	1/20/15

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C 664	Continued From page 3 he would obtain documentation of the attendance of those meetings. On 12/4/14 at 5:00 PM, the DNS provided sign-in sheets from the facility's Infection Control meetings, covering the previous three months. Neither the facility's medical director nor the pharmacist was documented to be in attendance. The DNS stated because the facility was in such a remote location it was difficult to get the pharmacist to attend in person, and the medical director was the only physician in the community so did not always have time to attend. The DNS provided signature sheets that the medical director and pharmacist had signed on a later date, which the DNS stated was when she updated them on what had been discussed at the Infection Control meeting. When asked, the DNS stated she had not considered asking the pharmacist and medical director to participate in the meeting via conference call at least once per quarter. On 12/4/14 at 6:45 PM, the Administrator, DNS, and ADON were informed of these findings. The facility offered no further information.	C 664		
C 669	02.150,03 Resident Protection 03. Patient/Resident Protection. There is evidence of infection control, prevention and surveillance in the outcome of care for all patients/residents as demonstrated by: This Rule is not met as evidenced by: Please see F 441 as it pertains to infection control.	C 669	C669 Please refer to F 441	

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C 679	02.151,03,d Individualized Activity Plan d. Develop and implement an individual activity plan for each patient/resident which reflects the interests and needs of the patient/resident. This Rule is not met as evidenced by: Please see F 248 as it pertains to the facility activities program.	C 679	C679 Please refer to F 248	
C 696	02.152 Social Services Program 152. SOCIAL SERVICES. The facility shall provide for the identification of the social and emotional needs of the patients/residents either directly or through arrangements with an outside resource and shall provide means to meet the needs identified. The program shall be accomplished by: This Rule is not met as evidenced by: Please refer to F 250 as it relates to medically necessary Social Service needs.	C 696	C696 Please refer to F250	
C 779	02.200,03,a,i Developed from Nursing Assessment i. Developed from a nursing assessment of the patient's/resident's needs, strengths and weaknesses; This Rule is not met as evidenced by: Please refer to F 279 as it relates to the initial assessment of residents.	C 779	C779 Please refer to F279	
C 784	02.200,03,b Resident Needs Identified b. Patient/resident needs shall be	C 784	C784 Please refer to F309	

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C 784	Continued From page 5 recognized by nursing staff and nursing services shall be provided to assure that each patient/resident receives care necessary to meet his total needs. Care shall include, but is not limited to: This Rule is not met as evidenced by: Please refer to F 309 as it relates to not following the care plan.	C 784		