



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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February 4, 2014

Lori A. Bentzler, Administrator
Twin Falls Center
674 Eastland Drive
Twin Falls, ID 83301-6846

Provider #: 135104

Dear Ms. Bentzler:

On **December 17, 2013**, a Complaint Investigation survey was conducted at Twin Falls Center. Amy Barkley, R.N. and Susan Gollobit, R.N. conducted the complaint investigation. This complaint was investigated in conjunction with a second complaint.

During the investigation, the Director of Nurses (DoN), registered dietician, Administrator and at least five residents were interviewed.

The following documentation was reviewed:

- The identified resident's closed record;
- Incident/Accident Reports from June 2013 to September 2013;
- Resident Council Meeting minutes from June 2013 to September 2013;
- Grievances from June 2013 to September 2013;
- Physical and Occupational Therapy notes for June 2013 to September 2013; and
- The CNA (Certified Nurse Aide) Activities of Daily Living Flow Sheets for July 2013 to August 2013.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00006137

ALLEGATION #1:

The complainant stated that the identified resident was taken from the shower room, back to the resident's room, "parked" in front of the bathroom sink and left for 45 minutes without her call light. The resident attempted to self-transfer from the shower chair, fell and injured her left knee.

FINDINGS:

The identified resident was admitted to facility on July 31, 2013, and discharged home on August 29, 2013, and therefore was unable to interview. The resident was admitted with multiple diagnoses and was at the facility for rehabilitation.

Five residents were interviewed by the surveyors and asked if they had any concerns related to the care needs being met by the facility. The residents stated they were happy with the care and did not have any concerns at this time.

Grievances June 2013 to September 2013 did not document concerns related to residents being left in their rooms and unattended to for extensive periods, for example greater than 45 minutes.

Resident Council Meeting minutes June 2013 to December 2013 did not document concerns related to increased wait times by residents before they received assistance from staff.

The resident's Minimum Data Set (MDS), under Brief Interview Mental Status (BIMS), coded the resident was cognitively intact, indicating the resident was alert and oriented to person, place, time and event.

The resident's Admission Activities of Daily Living (ADL) Care Plan dated July 10, 2013, and the Certified Nurse Aide (CNA) care plan dated July 10, 2013, documented the resident was a two person extensive/total dependent Hoyer lift for transfers.

Review of the facility's policy on transfers, specifically the procedure for Hoyer lifts, documented all Hoyer lift transfers are a mandatory two-person procedure.

A Fall Investigation Report dated July 31, 2013, at 5:10 p.m. documented the identified resident was taken to her room after a shower and requested the CNA to place her in front of the mirror so she could brush her hair. The CNA did as the resident requested and placed the call light within the resident's reach. The CNA explained to the resident that she (the CNA) needed to leave the room to find additional assistance before the resident could be transferred. In addition, the CNA instructed the resident to use her call light if she needed assistance before the CNA returned. The

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CNA stated she was gone for approximately 5-10 minutes, and when she returned with help, they found the resident on the floor. After the resident fell, she complained of left knee pain. The physician was notified on July 31, 2013, at 7:00 p.m., at which time he gave orders to apply ice to the resident's left knee, administer pain medication as necessary and he would follow-up with the resident on August 1, 2013.

The Physicians Progress Notes dated August 1, 2013, documented the physician went to the facility to follow-up with the identified resident related to the fall she had on July 31, 2013. The physician documented that he had told the resident she should not attempt to transfer herself because it was unsafe. In addition, he reminded her to use her call light to request help. The physician increased the resident's pain medication and gave an order for the resident to be non-weight bearing on her left knee pending x-ray. The resident was sent to the physician's office for an x-ray of her left knee, and the results of the x-ray documented "Zero acute fracture seen. Severe degenerative arthritis."

Note: For clarification purposes, the resident was non-weight bearing with nursing staff but was working with Physical Therapy on her sit to stands in the parallel bars and pivot transfers. It is important to understand why the order was given by the physician for the resident to be non-weight bearing.

The resident was provided education by nursing staff, physical therapy and the physician after the fall related to asking for help and potential negative outcome if she continued to transfer herself.

CNAs were directed to activate the resident's call light and wait when additional help was required.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The complainant stated the facility was "bad" about getting people out of bed, and a CNA refused to perform a "one man transfer" with the resident on August 9, 2013, after the resident was cleared by the Physical Therapist for a one-person transfer.

FINDINGS:

Physical Therapy's notes and nursing notes were reviewed from July 10, 2013 to September 29, 2013, and did not document the identified resident was "non-compliant or unmotivated" with getting out of bed or participating in therapy. Therapy notes documented, the resident was

motivated to get stronger and become more independent, as the resident told the therapist she wanted to be discharged from the facility by September 29, 2013.

Grievances and Resident Council Meeting minutes reviewed did not document concerns from the identified resident nor other residents related to staff not getting residents up when they requested or leaving them in bed for prolonged periods.

Five residents were interviewed related to the care they received in the facility and did not verbalize concerns related to staff not getting them up in a timely manner or when the residents requested to get out of bed.

According to July and August 2013 Physical Therapy Notes, the identified resident had not been cleared by therapy to transfer with a one-person assist.

The Physical Therapy Notes documented the following:

- August 8, 2013 to August 14, 2013, the resident was a minimum to moderate assist with sit to stand transfers in the parallel bars.
- August 15, 2013 to August 21, 2013, the resident had a goal of performing a pivot transfer from her wheelchair to the bed with stand by assist.
- August 21, 2013, the resident had made significant progress and was able to transfer using stand by assist to contact guard assist of one person. The therapy notes documented the resident was "adamant" about returning home on August 29, 2013, and often required minimum to moderate assist of one person for transfers, which would be a problem for her at home.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The complainant stated the identified resident had diabetes and checked her blood sugars twice a day at home. Upon admission to the facility, on July 10, 2013, and for four weeks after the resident's admission, the facility did not check the resident's blood sugars. In addition, the facility was giving the resident snacks "loaded with sugar."

FINDINGS:

The resident's Admission Orders and the July 2013 and August 2013 Physician's Orders did not document an order for blood sugars to be checked daily on the resident, as her diabetes was

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controlled with an oral diabetic medication. The facility requested an order from the physician on August 6, 2013, after it was brought to the facility's attention, for daily blood sugar checks. The resident's blood sugars were checked daily starting August 6, 2013, until the resident discharged on August 29, 2013. The blood sugars were within the defined limits of the physician's orders.

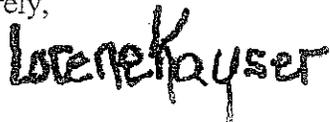
The resident was on a house consistent carbohydrate regular diet. The dietician stated that she or the Dietary Manager interview the resident upon admission related to food intolerance and the resident's preferences for breakfast, lunch, dinner and snacks. In addition, the dietician stated each resident's snacks are customized to the resident's preferences and provided within the parameters of the physician's dietary orders.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

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

Sincerely,

A handwritten signature in black ink that reads "Lorene Kayser". The signature is written in a cursive, slightly slanted style.

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

LKK/dmj



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January 21, 2014

Lori A. Bentzler, Administrator
Twin Falls Center
674 Eastland Drive
Twin Falls, ID 83301-6846

Provider #: 135104

Dear Ms. Bentzler:

On **December 17, 2013**, a Complaint Investigation survey was conducted at Twin Falls Center. Amy Barkley, R.N. and Susan Gollobit, R.N. conducted the complaint investigation. This complaint was investigated in conjunction with a second complaint.

During the investigation, the Director of Nursing (DoN) and administrator were interviewed. A tour was conducted to determine availability of water, call light placement, staff response to resident needs, etc. Approximately ten residents and one family member were interviewed regarding their care at the facility. The facility and hospital records were reviewed for the identified resident and another resident.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00006287

ALLEGATION #1:

The complainant stated that upon admission to the facility Steroid orders for an identified resident were "messed up."

FINDINGS:

The records reviewed documented there were conflicting orders for the Dexamethasone when the

resident was admitted to the facility. The discharging medical doctor's (MD) orders from the hospital were not the same as the admitting orders to the facility.

On December 17, 2013, the DoN was interviewed and stated that the resident was supposed to be on a scheduled tapering dose of the medication. The DoN set up a timeline and it was determined that the hospital's clinician had the orders inaccurate. The DoN contacted the two doctors involved in the resident's care. He clarified the orders through the medical director and then the hospital MD.

The MD orders for October and November documented the changes in the doses for the Dexamethasone. The Medication Administration Record for October and November documented the Dexamethasone was given as ordered by the MD.

The timeline that the DoN completed was reviewed.

This allegation was not substantiated. The DoN determined there was conflicting orders for the Dexamethasone and had gotten order clarifications.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The complainant stated the identified resident was complaining of "stomach pain." The facility said she may have been constipated and gave her a suppository. The complainant further stated the resident would not ask for pain medication; staff needed to ask if she wanted it. The facility did not treat her pain. She was admitted to the hospital with urinary sepsis and possible bowel issues.

FINDINGS:

On admission to the facility, the resident had diagnoses that included brain cancer and a urinary tract infection (UTI). The resident was admitted with Norco for pain and Levaquin 250 mg (milligrams) daily for the UTI.

MD (Medical doctor's) orders for pain medication dated October 1, 2013, the date of admission, documented:

- Hydrocodone 5/Acet (Acetaminaphen) 325 mg (milligrams) 1-2 q (every) 6 (hours) PRN (as needed) for pain.

- Order clarification on October 2, 2013, documented Norco 5/325 mg 1 q 8 hours PRN for pain.
- Order change on November 13, 2013, documented Norco 5/325 mg q 8 hours and q 4 hours PRN for pain.

Care sheets for October, November and December 2013 revealed that the resident was asked about pain on all three shifts. The form documented the level of pain the resident had and when pain medication was administered.

Abdominal assessments completed in the Interdisciplinary notes included documented dates of October 9 and November 13, 14, 27 and 28, 2013.

A Gastrointestinal Assessment form for every shift was implemented on November 13, 2013. The form was documented on every shift after initiated.

The MD had assessed the resident in the facility and had documented visits on October 2, 7, 14, 25, 30 and November 6, 13, 20, 27, 2013.

Lab results documented a urinalysis was completed on October 8, 2013. On November 20, 2013, a urinalysis for protein was completed. MD documentation stated he was waiting until culture and sensitivity results had returned to decide if he wanted to start an antibiotic. On November 24, 2013, a culture was completed. The MD was notified and asked if he wanted an antibiotic started. On November 26, 2013, there was an MD order for a clean catch or straight cath (catheter) urinalysis to clarify if she had an UTI or not. On November 27, 2013, the resident was started on Cipro 250 mg twice a day. When the culture and sensitivities returned on November 29, 2013, the Cipro was discontinued because the bacterium growing was resistant to the medication. On November 29, 2013, Rocephin 2 gm (grams) (intramuscular) daily was started.

The resident was admitted to the hospital on December 2, 2013. The hospital's daily Inpatient Progress notes completed by the MD documented:

- December 3, 2013, 1. "Sepsis presumed secondary to urinary tract infection (moderately resistant proteus was grown as an outpatient)."
- December 6, 2013, 1. "Sepsis. This is due to pelvic abscess and proteus UTI."

On December 17, 2013, the DoN was interviewed. He stated he spoke with the MD when he found out about the diverticuli abscess. The DoN requested information on education and training in regards to how they could have assessed for the abscess. The MD told him there is no way to diagnosis that without a CT (computerized tomography) scan.

The allegation was not substantiated. The facility assessed the resident for pain at least every shift and provided medications when needed. The facility increased the pain medication to "scheduled" and "as needed" doses. The MD visited the resident nine times in the two months prior to the admission to the hospital. The facility completed abdominal assessments and urinalysis. When the urinalysis revealed an infection, the resident was started on an antibiotic, and when the culture and sensitivity came back, an appropriate medication change was completed. The hospital initially admitted the resident on December 2, 2013, with the diagnosis of "Sepsis presumed secondary to urinary tract infection." Documentation on December 6, 2013, stated "Sepsis. This is due to pelvic abscess and Proteus UTI."

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The complainant said the facility would only change incontinent briefs every two hours, and the resident's bottom and groin was very excoriated and raw.

FINDINGS:

The resident's Skin Integrity Report documented:

- October 1, 2013, "Intact/Pink. Denuded area blanchable, surrounding tissue healthy." The buttocks/peri-area in the figure on the form was marked.
- October 7, 2013, "Pink -closed. Blanchable. Resolved."

MD (medical doctor's) orders on October 2, 2013, documented:

- Desitin 13 gm (gram) cream topical q (every) shift q (every) day. Apply to inner buttocks 3 (times a day) and PRN (as needed) - Denuded skin.
- Biweekly skin checks - (evening) Mon- Thur
- T & P (turn and position) (every) 2 (hours) and PRN.

The Medication Administration Record for October and November, 2013 documented Desitin was applied as ordered, biweekly skin checks were completed and the resident was turned and positioned as ordered.

On November 5, 2013, the facility implemented every hour checks for the resident. Interdisciplinary Progress notes for this specific task were implemented. Checks were completed hourly and at times every half hour. Notes of briefs being changed, fluids being offered and

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cares performed by the CNA were documented.

On December 17, 2013, the DoN was interviewed. When asked about the cares for the resident, he provided the hourly Interdisciplinary Progress notes. He stated that the facility had implemented the hourly checks to provide a closer watch on the resident.

The resident was admitted to the facility with reddened, denuded skin to the buttocks area. The facility implemented a barrier cream, skin checks and every two-hour turning and positioning. In November, the facility increased the care checks to hourly. The resident's skin condition was resolved during her stay in the facility. The hospital record dated December 2, 2013, did not document skin issues to the buttocks upon admission.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

The complainant stated facility staff would not give the identified resident a drink when she asked.

FINDINGS:

CNA (Certified Nurse Aide) Care notes for October and November 2013 were reviewed for the identified residents. They documented fluid intakes for meals to be 300+ cc to 400+ cc.

On December 16, 2013, at 12:50 p.m., the assisted dining room was observed. There were fourteen residents present. All fourteen residents were provided drinks in two or three cups, to include; hot beverages, juice, water, milk. The residents were being offered and encouraged to drink the fluids provided.

Four random residents were interviewed concerning access to water and water being provided. All four residents stated they were provided with water and access to water. Eleven rooms were observed with water pitchers at bedside, all within easy access of the resident.

At 2:40 p.m., a CNA was observed pushing a metal serving cart down the 300 hall with water and ice. She was filling the water pitchers in the rooms.

On December 17, 2013, the DoN was asked about the identified resident being provided water. The November Interdisciplinary Progress Notes and hourly CNA checks provided documented the resident was being offered fluids. The DoN stated, "(Resident name) always had water and

juice at the bedside, and she was able to drink it on her own."

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #5:

The complainant stated the facility did not ensure the call light and telephone was within reach.

FINDINGS:

During the investigation, records were reviewed, observations were completed and residents were interviewed.

Interdisciplinary Notes documented the identified resident was calling out for help. The staff discussed the use of the call light with the resident. The resident did not like using the call light and would call out, "Is anybody out there?"

On December 16, 2013, during observations of fourteen rooms, call lights were all noted to be within reach of the residents. Residents were observed in their wheelchairs with call lights in their laps, call lights were on bedside tables near the residents or hooked on beds within reach of the residents.

Four residents and one family member were interviewed concerning cares being provided in the facility. There were no concerns identified.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #6:

The complainant said the resident had gained a lot of weight. The wheelchair she was sent to the doctor's office in was too small.

FINDINGS:

The identified resident's Weights and Vitals Summary sheet documented: Weight on October 2, 2013, as 229.5 and on December 2, 2013, as 229.5.

On October 24, 2013, the resident was started on Lasix 20 mg. every day for edema.

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The size of the identified resident's wheelchair could not be determined at the time of the investigation. On December 16, 2013, fourteen residents were observed in wheelchairs. All wheelchairs were appropriate in size for the residents. Four residents were asked about their wheelchair, and no concerns were expressed.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

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

Sincerely,

A handwritten signature in black ink that reads "LORENE KAYSER". The letters are somewhat stylized and slanted.

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

LKK/dmj