



IDAHO DEPARTMENT OF
HEALTH & WELFARE

G.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

January 5, 2015

Darwin G. Royeca, Administrator
Lincoln County Care Center
511 East Fourth Street, PO Box 830
Shoshone, ID 83352-1502

FILE COPY

Provider #: 135056

Dear Mr. Royeca:

On **December 18, 2014**, a Recertification, Complaint Investigation and State Licensure survey was conducted at Lincoln County 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 one that comprises a pattern that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies and a similar State Form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 3). **Please provide ONLY ONE completion date for each federal and state tag in column (X5) Completion Date** to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.

After each deficiency has been answered and dated, the administrator should sign both 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 20, 2015**. Failure to submit an acceptable PoC by **January 20, 2015**, may result in the imposition of civil monetary penalties by **February 9, 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*.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS), if your facility has failed to achieve substantial compliance by **January 22, 2015 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **January 22, 2015**. A change in the seriousness of the deficiencies on **January 22, 2015**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **January 22, 2015** includes the following:

Denial of payment for new admissions effective **March 18, 2015**. [42 CFR §488.417(a)]

Darwin G. Royeca, Administrator
January 5, 2015
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If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **June 18, 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 & Medicaid Services determine that termination or any other remedy is warranted, they 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, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, Option #2; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **December 18, 2014** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the noncompliance at the time of the revisit, if appropriate.

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

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

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

- BFS Letters (06/30/11)

2001-10 Long Term Care Informal Dispute Resolution Process

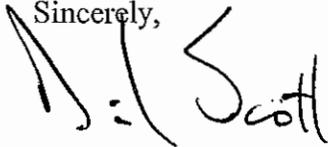
Darwin G. Royeca, Administrator
January 5, 2015
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2001-10 IDR Request Form

This request must be received by **January 20, 2015**. If your request for informal dispute resolution is received after **January 20, 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, Option #2.

Sincerely,

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

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

DS/dmj
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135056	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/18/2014
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NAME OF PROVIDER OR SUPPLIER LINCOLN COUNTY CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 511 EAST FOURTH STREET SHOSHONE, ID 83352
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	INITIAL COMMENTS The following deficiencies were cited during the annual federal recertification survey of your facility. The surveyors conducting the survey were: ---Lauren Hoard, RN BSN - Team Coordinator Brad Perry, BSW LSW The survey team entered the facility on 12/15/14 and exited on 12/18/14. Survey Definitions: ADL = Activities of Daily Living BIMS = Brief Interview for Mental Status cm = Centimeters CNA = Certified Nurse Aide DON = Director of Nursing LN = Licensed Nurse MAR = Medication Administration Record MDS = Minimum Data Set assessment PRN = As Needed	F 000		
F 164 SS=E	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this	F 164	<p style="text-align: right;">JAN 16 2015</p> <p>F 164 FACILITY STANDARDS</p> <p>PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The facility will ensure that privacy is maintained while injections are administered in the resident's abdomen.</p> <p>Resident #5, #13, #14 and #1 were interviewed and observed by the Administrator and Resident Services Director if the deficient practice has cause negative affect of their psychological well-being.</p> <p>Resident #5, #13, #14 and #1 have all been asked the following questions on 1/08/15:</p> <ol style="list-style-type: none"> Has the Licensed Nurse been providing you enough privacy when administering injection in your abdomen? All of them said yes that Licensed Nurse has been providing appropriate privacy while giving blood sugar injection in the abdomen. 	1/16/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Darwin S. Royce</i>	TITLE Administrator	(X6) DATE 1/16/15
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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.

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F 164	<p>Continued From page 1 section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure privacy was maintained while injections were administered in residents' abdomens. This was true for 2 of 9 (#s 1 & 5) sampled residents and 2 of 2 (#s 13 & 14) random residents observed to receive subcutaneous insulin injections. This failed practice created the potential to negatively affect the resident's psychosocial well-being related to the need for privacy. Findings included: On 12/17/14 at 11:10 a.m., LN #1 was observed during the medication pass entering Resident #5's room to administer an insulin injection. The resident was seated on the side of the bed partially facing the hallway as the resident's abdomen was exposed and 28 units of Humalog insulin was administered in the abdomen while the door to the resident's room was wide open.</p>	F 164	<p>2. If you feel that your personal privacy is not met, Do you know that you can always tell the Licensed Nurse to provide you of the privacy that you needed and you can also report them to the Administrator, Director of Nursing Services and Resident Services Coordinator? All of the 4 resident said Yes and that they know they can tell the Licensed Nurse to provide them of the privacy they need and they can also report when their needs are not met.</p> <p>3. During Survey week, Do you remember if any of your personal privacy being violated when the Licensed Nurse was administering injection in your abdomen? All 4 residents believe that their personal privacy has not been violated.</p> <p>From observation and by the answer the residents have given upon interview, the facility feels that there were no negative affect of resident's psychological well being on this deficient practice.</p>	
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F 164	<p>Continued From page 2</p> <p>On 12/17/14 at 11:25 a.m., LN #1 was observed entering Resident #13's room to administer an insulin injection. The resident was seated in a wheelchair facing the window as the resident's abdomen was exposed and 6 units of Novolog insulin was administered in the abdomen while the door of the resident's room was wide open.</p> <p>On 12/17/14 at 11:30 a.m., LN #1 was observed entering Resident #14's room to administer an insulin injection. The resident was seated in a wheelchair facing the television as the resident's abdomen was exposed and 11 units of Novolog insulin was administered in the resident's abdomen while the door of the resident's room was wide open.</p> <p>On 12/17/14 at 11:40 a.m., LN #1 was observed entering Resident #1's room to administer an insulin injection. The resident was seated in a wheelchair facing the television as the resident's abdomen was exposed and 22 units of Novolog insulin was administered in the resident's abdomen while the door of the resident's room was wide open.</p> <p>On 12/17/14 at 11:55 a.m., LN #1 was asked how privacy during insulin injections in the abdomen was maintained for the residents. The LN said to protect resident privacy the curtain should be pulled or the door should be closed.</p> <p>On 12/17/14 at 3:25 p.m., the Administrator and DON were informed of the privacy concern. No further information was provided.</p>	F 164	<p>All residents have the potential to be affected by this practice.</p> <p>Staff were in serviced on Federal tag and deficient practice. All Licensed Nurse administering injections in resident's abdomen will ensure to provide personal privacy by pulling the privacy curtains and closing the door so residents will not be exposed to other residents, staffs and visitors.</p> <p>Random Privacy Audits on both Hallways will be done weekly and was started on 12/30/14. Random Licensed Nurse will be audited weekly for compliance.</p> <p>Please See Exhibit A.</p> <p>Director of Nursing Services or Department head assigned will complete an audit weekly X 4 and then every two weeks X 4 and then monthly X 3.</p> <p>Department head will sign the completed audit sheet and turn into the D.N.S. for review.</p> <p>IDT will review the audits. weekly X 4, then every 2 weeks X 4, then monthly X 3.</p> <p>All audits will be reviewed at monthly CQI meeting.</p>	
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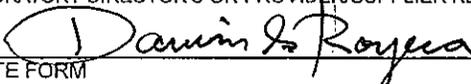
Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001860	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/18/2014
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NAME OF PROVIDER OR SUPPLIER LINCOLN COUNTY CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 511 EAST FOURTH STREET SHOSHONE, ID 83352
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C 000	16.03.02 INITIAL COMMENTS The following deficiencies were cited during the State licensure survey of your facility. The surveyors conducting the survey were: Lauren Hoard, RN BSN - Team Coordinator Brad Perry, BSW LSW	C 000	<p style="text-align: center;">RECEIVED JAN 16 2015 FACILITY STANDARDS</p> <p>Please refer to F 164.</p>		
C 125	02.100,03,c,ix Treated with Respect/Dignity ix. Is treated with consideration, respect and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; This Rule is not met as evidenced by: Refer to F164 as it relates to privacy during medical treatment and personal cares.	C 125			
C 411	02.120,05,k All Resident Rooms Numbered k. All patient/resident rooms shall be numbered. All other rooms shall be numbered or identified as to purpose. This Rule is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure 3 rooms in the facility were labeled. This had the potential to affect residents or visitors attempting to locate a specific room or person. Findings included: On 12/15/14 from 10:28 to 10:40 AM, the following rooms were observed not to have any identification on them: * A medical supply closet between rooms 25 and 27; *A housekeeping closet between a soiled utility room and the resident phone room; and, *A linen closet off the dining room.	C 411		<p>C 411</p> <p>ALL RESIDENT ROOMS NUMBERED</p> <p>The facility will ensure that all rooms are numbered or identified as to the purpose.</p> <p>On December 15, 2014, all doors have been inspected and identification or room label have been placed to identify the purpose.</p>	1/16/15

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 1/16/15
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C 411	Continued From page 1 On 12/15/14 at 10:45 AM, the Administrator was shown these rooms and he said he would make sure labels were placed on the doors.	C 411	<p>All the 3 rooms that were cited have already been labeled to identify the purpose.</p> <p>All residents and staff have the potential to be affected by this practice.</p> <p>Staff were in serviced on this Citation and deficient practice.</p> <p>Maintenance Director will complete a weekly door signage inspection and audit to ensure that all doors have identification or room label to identify the purpose. Administrator will sign the completed weekly inspection and Audit.</p> <p>Audits and Inspections was started on 12/22/14.</p> <p>Please See Exhibit B.</p> <p>All audits will be reviewed at monthly CQI meeting.</p>	
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January 5, 2015

Darwin G. Royeca, Administrator
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511 East Fourth Street, PO Box 830
Shoshone, ID 83352-1502

FILE COPY

Provider #: 135056

Dear Mr. Royeca:

On **December 18, 2014**, a Complaint Investigation survey was conducted at Lincoln County Care Center. Lauren Hoard, R.N. and Bradley Perry, L.S.W. conducted the complaint investigation. The complaint was investigated in conjunction with the facility's Recertification and State Licensure survey conducted on December 18, 2014.

The following observations were completed:

- Call lights were observed throughout the survey.

The following documents were reviewed:

- The entire medical record of three identified residents;
- Nine other residents' records were reviewed for quality of care concerns;
- The facility's grievance file from September and October 2013 and September 2014 to December 2014;
- Resident Council minutes from September 2014 to December 2014;
- The facility's Incident and Accident reports from July 2014 to December 2014;
- The facility's Allegation of Abuse reports from September and October 2013 and September 2014 to December 2014; and,
- Criminal background checks for three staff members, which included two from September and October 2013.

The following interviews were completed:

- The Resident Group interview was held with eight residents in attendance;
- Several residents were interviewed regarding quality of care concerns;
- The Director of Nursing (DoN) and the Administrator were interviewed regarding various quality of care concerns;
- Several Certified Nurse Aides (CNAs) and Licensed Nurses (LNs) were interviewed regarding Quality of Care concerns;
- A Social Services Designee was interviewed about staff visitors and new employee training on abuse and neglect; and,
- Two family members were interviewed regarding quality of care concerns and call lights.

Eleven of the fourteen identified residents were no longer residing in the facility at the time the complaint was investigated.

The complaint allegations, findings and conclusions are as follows:

Complaint #6253

ALLEGATION #1:

The complainant stated an identified resident fell and sustained a pelvic fracture due to lack of supervision sometime between October 13, 2014 and October 24, 2014.

FINDINGS #1:

The identified resident's entire medical record was reviewed. The resident wore a self-releasing seat belt with an alarm to inform staff of attempts to stand, and the resident was on every 15-minute checks to ensure safety. There was no documented evidence of the resident sustaining a fall with a fracture in October 2014.

The Director of Nursing was interviewed and said if a resident has a history of or has frequent falls they are put on every 15-minute checks. The residents are provided with extra group activities, one-on-one supervision and care kits if needed. The Director of Nursing was unable to recall any resident fall with a fracture from September 2013 to December 2014.

Based on the records reviewed and staff interviews, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The complainant stated two residents' call lights were not answered consistently, and an identified resident's call light was ignored because staff would go into the room, and the resident would forget why he/she turned it on in the first place.

FINDINGS #2:

Call lights were observed during the survey and were found to be answered immediately and/or in less than five minutes.

Interviews with three individual residents, two family members and the Resident Group interview were conducted. There were no concerns with call light response time.

Three Certified Nurse Aides were interviewed, and they said call lights are answered within minutes, and if a resident used a call light repetitively, they would still answer it each time.

The Director of Nursing was interviewed and said nursing staff make rounds and have assignments. Staff are taught to check on high-risk-for-fall residents first, residents on every 15-minute checks second and then residents with skin issues were checked. The Nurse Managers performed audits of call lights and it was discussed during Resident Council. The call light system was located near the Director of Nursing's office, enabling her to monitor them.

Based on observations, records reviewed and interviews, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The complainant stated several identified residents, some of whom had passed away, had bleeding buttocks because they were not being turned and toileted enough.

FINDINGS #3:

Nine residents were observed for quality of care and no issues were found.

The entire closed medical records for two identified residents were reviewed. One of the identified residents was admitted to the facility with excoriation and had hemorrhoids. Documentation showed the resident's buttocks was monitored daily for skin breakdown, and the resident was toileted and turned per the plan of care. The second identified resident passed away

on October 6, 2013, with no skin issues. Documentation showed the resident was on comfort measures and was turned/repositioned and toileted per the plan of care.

Three Certified Nurse Aides were interviewed, and they each said they turn residents according to their care plan and at least every two hours. If a red area or bleeding is noted, they contact the charge nurse immediately.

Four Certified Nurse Aides were interviewed and each said they toilet residents per request, when the toileting plan directs, when the resident is observed to be soiled and as needed. They said they would not allow a resident to stay in a soiled brief and would change it immediately.

The Director of Nursing was interviewed and said random audits were performed to ensure residents were toileted and repositioned as directed in the plan of care. She said residents are toileted before and after meals and repositioning takes place every 1-2 hours unless otherwise directed.

Based on observations, records reviewed and staff interviews, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

The complainant stated an identified resident was left in soiled briefs, which had leaked onto the wheelchair.

FINDINGS #4:

Nine residents were observed for quality of care and no issues were found.

Four Certified Nurse Aides were interviewed, and they each said they toilet residents per request, when the toileting plan directs, when the resident is observed to be soiled and as needed. They said they would not allow a resident to stay in a soiled brief and would change it immediately.

The Director of Nursing was interviewed, and she said random audits were performed to ensure residents were toileted as directed in the plan of care. She said residents were toileted before and after meals and per plan of care.

The Social Services Designee was interviewed and said; upon hire, new staff have a two-day in-class training, which addresses abuse and neglect. Staff are told that if they suspect or witness neglect to let the person know it was wrong and to immediately report it to any member of

management they feel comfortable with, regardless of whether it was the person who was training who was the offender. Abuse and neglect would not be tolerated.

Based on observations and staff interviews, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #5:

The complainant stated several identified residents were being put to bed even when they wanted to stay up.

FINDINGS #5:

Two of the three identified residents no longer resided in the facility at the time the complaint was investigated.

Grievances and Resident Council minutes were reviewed and revealed no complaints about being required to go to bed at a certain time.

An interview was attempted for an identified resident, but the resident was cognitively impaired and could not comprehend the questions.

During the Resident Group interview with eight residents in attendance, residents said there was not a scheduled bedtime, and residents could stay up as long as they wanted.

Two Certified Nurse Aides were interviewed and said they would allow residents to stay up because it was their right to do so.

The Director of Nursing was interviewed and said if a resident wanted to be in bed by a particular time it would be in the care plan for that resident, otherwise staff accommodate residents' choices allowing them to stay up if desired.

Based on records reviewed and interviews, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #6:

The complainant stated five identified residents passed away in the last two months due to poor quality of care.

FINDINGS #6:

Observations were made during the survey for quality of care. No issues were found.

Discharge records were reviewed and showed one identified resident expired in the facility, three identified residents were transferred to a local hospital and one identified resident could not be reviewed due to lack of information.

One of the identified resident's entire medical record was reviewed and showed no issues or concerns related to quality of care.

Grievances were reviewed and showed no complaints regarding quality of care.

Three residents were interviewed and had no concerns with quality of care.

The Resident Group interview revealed no concerns with quality of care.

Two family members were interviewed with no complaints or concerns related to quality of care.

Based on observations, records reviewed and interviews, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #7:

A registered sex offender came into the facility at night to visit a staff member.

FINDINGS #7:

Grievances were reviewed and showed no complaints regarding visitors of residents or staff.

The residents who participated in the Resident Group interviewed said they had no concerns with visitors and were not aware of any resident or staff visitors at night.

The Administrator and Social Services Designee were interviewed and neither were aware of a

Darwin G. Royeca, Administrator
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resident or staff family member being a registered sex offender and that such a visitor would have supervised visits while in the facility.

Based on records reviewed and interviews, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #8:

The complainant said new employees did not have their fingerprint background check completed by the Idaho Criminal History in a timely manner.

FINDINGS #8:

Three employees' personnel files were reviewed and revealed one employee missed his/her scheduled fingerprint appointment, which had to be rescheduled.

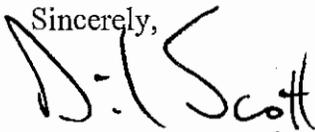
Based on records reviewed, it was determined the allegation could not be substantiated.

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 "D. Scott". The signature is written in a cursive, somewhat stylized font.

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

DS/dmj