



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 29, 2014

FILE COPY

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

Provider #: 135104

Dear Ms. Bentzler:

On **December 18, 2014**, we conducted an on-site follow-up revisit to verify that your facility had achieved and maintained compliance. We had presumed, based on your allegation of compliance, that your facility was in substantial compliance as of **November 13, 2014**. However, based on our on-site follow-up revisit conducted **December 18, 2014**, we found that your facility is not in substantial compliance with the following participation requirements:

**F315 -- S/S: D -- 42 CFR §483.25(d) -- No Catheter, Prevent UTI, Restore Bladder**  
**F328 -- S/S: D -- 42 CFR §483.25(k) -- Treatment/Care for Special Needs**

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. **Please provide ONLY ONE completion date for each federal and state tag in column X5 Completion Date** to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.

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

Your copy of the Post-Certification Revisit Report, Form CMS-2567B, listing deficiencies that have been corrected is enclosed.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **January 12, 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*.

As noted in the letter of **October 10, 2014**, as a result of our finding that your facility was not in substantial compliance, we notified the Centers for Medicare & Medicaid Services (CMS) and their letter dated October 31, 2014, included recommendations for imposition of the following remedies:

**Denial of payment for new admissions effective December 26, 2014.**

**A 'per instance' civil money penalty of \$3200.00.**

We also recommended to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **March 26, 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, it will provide you with a**

Lori A. Bentzler, Administrator  
December 29, 2014  
Page 3 of 3

**separate formal notification of that determination.**

STATE ACTIONS effective with the date of this letter (**December 29, 2014**): **NONE**

If you believe the 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.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You may also contest scope and severity assessments for deficiencies, which resulted in a finding of SQC or immediate jeopardy. 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 12, 2015**. If your request for informal dispute resolution is received after **January 12, 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 on-site follow-up revisit 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,



LORENE KAYSER, L.S.W., Q.I.D.P., Supervisor  
Long Term Care

LKK/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:  135104	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  R-C 12/18/2014	
NAME OF PROVIDER OR SUPPLIER  TWIN FALLS CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 674 EASTLAND DRIVE TWIN FALLS, ID 83301		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 315}	<p>Continued From page 1</p> <p>resident. This was true for 1 of 8 (#2) sampled residents. There was a potential for harm to the resident due to a loss of bladder function and the secondary effects of incontinence. Findings include:</p> <p>Resident #2 was admitted to the facility 7/16/14, and readmitted on 9/12/14, with diagnoses of unspecified acute renal failure, paralysis agitans and diabetes without complications Type II.</p> <p>The most recent Significant Change MDS, dated 9/19/14, documented the resident had moderately impaired cognition with a BIMS of 12; required extensive assistance with transfers, and toilet use; and was frequently incontinent of urine.</p> <p>The resident's care plan revealed the resident was on a timed toileting program. The 9/23/14 care plan for incontinence included the following intervention: - Assist the resident to the toilet at scheduled times i.e. upon rising, before meals, at HS [bed time] and as needed.</p> <p>December 2014 ADL flow sheets revealed the resident was still frequently incontinent of urine. The resident had as many as 3 episodes of incontinence per shift on 12 days.</p> <p>The facility's policy for toileting, with a revision date of 1/2/14, documented, "The 'Bowel and Bladder Continence Evaluation' will be completed if the patient is incontinent upon admission or re-admission and with a change in condition or change in continence status. Continent status will be reviewed quarterly and with significant change as part of the nursing assessment."</p>	{F 315}	<p><b>F 315</b></p> <p><u>Specific Residents Identified</u></p> <p>Resident #2 was discharged to the hospital on 12/18/14. Resident #2 was readmitted on 12/22/14 with a diagnosis of a urinary tract infection. A bladder assessment and toileting interventions were initiated on 12/22/14 by the Director of Nursing or designee. A new bladder assessment will be completed by the Director of Nursing or designee upon completion of treatment for resident #2's urinary tract infection and care plan updated.</p> <p><u>Identification of Other Residents</u></p> <p>A bowel and bladder assessment was completed by the Director of Nursing or designee on or before 12/24/14 for those residents needing assistance and/or with a toileting plan. Residents identified to be incontinent had a 72 hour voiding diary completed on or before 12/24/14. The assessment findings were reviewed and documented in the medical record and resident toileting care plans were updated by the Director of Nursing or designee on or before 12/24/14.</p>	

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{F 315}	<p>Continued From page 2</p> <p>Resident #2's medical record did not include documentation on how the IDT determined what interventions to put on the care plan. The "Bowel and Bladder Continence Evaluation" tool, dated 9/15/14 to 9/18/14, used by the facility was not complete. The 72 Hour Voiding Diary section of the form lacked sufficient information to make a determination as to the continence pattern of the resident. Steps 5, 6, and 7 of the form were the evaluation sections and these were not completed by an evaluator. No other documentation was present in the medical record of the resident's voiding history.</p> <p>On 12/18/14 at 12:50 PM, the DON and Unit Manager (UM) were interviewed about the process used to assess the resident. The UM stated she interviewed the resident and staff who cared for the resident. The resident's record and ADL flowsheets were reviewed and then changes were made to the resident's care plan. When asked where the documentation was for all the reviews that she completed, the unit manager was not able to produce any documentation of how and why she made the determination to do a timed toileting program for before meals etc., rather than a more time-specific program for the resident. The record lacked a written assessment containing preset criteria to develop a resident-specific toileting program.</p> <p>The interpretive guidance for F 315 states, "It is important that staff, when completing the comprehensive assessment, consider the following:</p> <ul style="list-style-type: none"> <li>- Prior history of urinary incontinence, including onset, duration and characteristics, precipitants of urinary incontinence, associated symptoms (e.g.,</li> </ul>	{F 315}	<p><u>Systematic Changes</u></p> <p>Nursing staff were educated by the Director of Nursing or designee on or before 12/24/14 regarding completion of incontinent assessments and toileting plans including the need to care plan current status and document plan in the medical record.</p> <p>Resident's bowel and bladder assessments will be reviewed by the interdisciplinary team starting the week of 12/26/14 during the morning clinical meeting to ensure that the assessment, care plan, and type of incontinence are documented in the medical record and are reflective of resident's current needs.</p>	

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{F 315}	Continued From page 3 dysuria, polyuria, hesitancy) and previous treatment and/or management, including the response to the interventions and the occurrence of persistent or recurrent UTI;  · Voiding patterns (such as frequency, volume, nighttime or daytime, quality of stream) and, for those already experiencing urinary incontinence, voiding patterns over several days;  · Medication review, particularly those that might affect continence ...;  · Patterns of fluid intake, such as amounts, time of day, alterations and potential complications, such as decreased or increased urine output;  · Use of urinary tract stimulants or irritants (e.g., frequent caffeine intake);  · Pelvic and rectal examination to identify physical features that may directly affect urinary incontinence ...;  · Functional and cognitive capabilities that could enhance urinary continence and limitations that could adversely affect continence ...;  · Type and frequency of physical assistance necessary to assist the resident to access the toilet, commode, urinal, etc. and the types of prompting needed to encourage urination;  · Pertinent diagnoses such as congestive heart failure, stroke, diabetes mellitus, obesity, and neurological disorders ...;  · Tests or studies indicated to identify the type(s) of urinary incontinence (e.g., post-void residual(s)	{F 315}	<b>Monitoring</b>  Beginning the week of 12/26/14, Director of Nursing or designee will review 5 bowel and bladder assessments weekly x 4 weeks and monthly x 2 months to ensure that the current toileting plans of the residents are accurate and the findings are documented in the medical record. Center Administrator will review audits weekly upon completion. A Report shall be reported to the Performance Improvement Committee for a minimum of 3 months or until compliance sustained. The Director of Nursing is responsible for monitoring and compliance  <b><u>Date of Compliance</u></b>  12/24/14	

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{F 315}	Continued From page 4 for residents who have, or are at risk of, urinary retention ... or evaluations assessing the resident's readiness for bladder rehabilitation programs..."  Resident #2's record did not include documentation that each of these areas was considered when evaluating the resident's continence status. The Administrator and DON were informed of this concern on 12/18/14 at 1:45 PM. No further information was provided.	{F 315}	
{F 328} SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS  The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.  This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure residents who use oxygen receive the liter flow as ordered by the physician. This was true for 2 of 6 residents (#s 26 and 27) reviewed for the proper care and treatment of oxygen (O2) therapy. This deficient practice created the potential for harm should residents have a drop in oxygen saturations causing them to become	{F 328}	F 328  <u>Specific Identified Residents</u>  Residents # 26 and #27's respiratory status was assessed by Director of Nursing or designee on or before 12/24/14 with no adverse effects noted. Resident's responsible parties and MDs were notified of oxygen administration on or before 12/24/14 with no concerns or new orders received.  On or before 12/24/14, resident #26's room oxygen concentrator was marked at the ordered rate by the Director of Nursing or designee due to the resident's independence of self adjusting to ensure that the setting is accurate.

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{F 328}	<p>Continued From page 5 anxious, confused and experience respiratory distress. Findings included:</p> <p>1. Resident #27 was admitted to the facility on 6/17/14 with multiple diagnoses which included rehabilitation, dependence on machine for supplemental oxygen, atrial fibrillation, hypertension and angina pectoris.</p> <p>The Medication Review Report (physician recapitulation orders), dated 11/3/14, documented an order, with a start date of 9/29/14, for oxygen at 3 L (liter) nasal cannula (NC), observe for s/sx (signs and symptoms of) of respiratory distress (i.e. cyanosis, pallor, increased respiratory rate, flared nostrils, etc). Notify MD for unrelieved s/sx respiratory distress every shift for asthma, OSA (obstructive sleep apnea).</p> <p>The care plan for risk of complications related to respiratory, dated 10/24/14, documented an intervention for O2 as ordered via nasal cannula.</p> <p>The TAR (Treatment Administration Record), for 12/1/14 - 12/31/14, documented the order for oxygen at 3 L NC via nasal cannula. The TAR contained documentation the O2 saturation was being monitored for three, eight hour shifts per day.</p> <p>On 12/17/14 at 1:00 PM, the resident was observed sitting in her room in a power chair with a nasal cannula which was connected to a portable oxygen tank at 2 L. The resident was also observed in the activity room playing a game of Bingo at 2:00 PM with her portable oxygen tank at 2 L.</p> <p>On 12/17/14 at 4:00 PM, the DON was asked</p>	{F 328}	<p><u>Identification of Other Residents</u></p> <p>A review including bedside rounds was completed by the Director of Nursing or designee on or before 12/24/14 of residents receiving oxygen administration to ensure physician orders were being followed. Any findings were corrected by the Director of Nursing or designee at the time of review.</p> <p><u>Systemic Changes</u></p> <p>Licensed nurses have been educated by the Director of Nursing or designee on or before 12/24/14 regarding accurately following physician orders for oxygen administration and implementation of those orders.</p> <p>On or before 12/24/14 licensed nurses have verified the accuracy of equipment setting one time per shift to ensure residents are receiving oxygen per physician orders</p>	

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{F 328}	<p>Continued From page 6</p> <p>about the resident's current oxygen order and verified the liter flow should be at 3 L. The DON and surveyor went to the resident's room where the DON observed the O2 liter flow was at 2 L. He stated, "It should be at 3 L." The DON stated he would direct staff to immediately place the O2 liter flow at 3 L. The DON later provided a copy of the SBAR (Situation, Background, Assessment and Request) Communication Form which documented the incorrect liter flow had been corrected and the resident had been assessed. Additionally, the form documented the resident's son and physician had been notified.</p> <p>2. Resident #26 was admitted to the facility on 7/30/14 and readmitted on 11/4/14 with multiple diagnoses which included rehabilitation, cardiac dysrhythmia, dependence on machine for supplemental oxygen, chronic kidney disease, and hypoxemia.</p> <p>The Order Summary Report (physician recapitulation orders) for 11/1/14 - 11/30/14, documented an order, with a start date of 11/4/14, for oxygen at 3 L via nasal cannula, observe for s/s (signs and symptoms) of respiratory distress (i.e. cyanosis, pallor, increased respiratory rate, flared nostrils, etc.). Notify MD of s/s of unrelieved respiratory distress. Maintain oxygen sats (saturation) parameters from 90% to 95%. Notify MD if oxygen is out of the parameters every shift for COPD (Chronic Obstructive Pulmonary Disease).</p> <p>The care plan for complications related to COPD and obstructive sleep apnea, dated 11/6/14, documented an intervention for O2 as ordered.</p> <p>The TAR, for 12/1/14 - 12/31/14, documented the</p>	{F 328}	<p><u>Monitoring</u></p> <p>Beginning the week of 12/26/14, a review of 5 residents with oxygen orders will be completed weekly x 4 weeks and monthly x 2 months by the director of nursing or designee to ensure physician orders are followed accurately. Center Administrator will review audits weekly upon completion. A Report shall be reported to the Performance Improvement Committee for a minimum of 3 months or until compliance sustained. The Director of Nursing is responsible for monitoring and compliance</p> <p><u>Date of Compliance</u></p> <p>12/24/14</p>

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{F 328}	<p>Continued From page 7</p> <p>11/4/14 order for oxygen at 3 L NC via nasal cannula. The TAR contained documentation the O2 saturation was being monitored for three, eight hour shifts per day.</p> <p>On 12/17/14 at 3:25 PM, the resident was observed sitting in a lounge chair with her legs up in her room. The resident stated she had recently returned from Dialysis. The resident was observed to receive oxygen via nasal cannula from the O2 concentrator in her room. The surveyor observed the oxygen level was at 2 L instead of the 3 L as ordered by the physician.</p> <p>On 12/17/14 at 4:40 PM, the DON was asked about the resident's current oxygen order and verified the liter flow should be at 3 L. The DON and surveyor went to the resident's room where the DON observed the O2 liter flow was at 2 L and stated, "It should be at 3 L." The DON stated he would direct staff to immediately place the O2 liter flow at 3 L. The DON later provided a copy of the SBAR Communication Form which documented the incorrect liter flow had been corrected and the resident had been assessed. Additionally, the form documented the resident's daughter and physician had been notified.</p> <p>Perry &amp; Potter's, Clinical Nursing Skills &amp; Techniques, 7th Edition, 2010, states on p. 262, "Treat oxygen therapy as a medication...As with any drug, continuously monitor the dosage or concentration of oxygen. Routinely check the health care provider's orders to verify that the patient is receiving the prescribed oxygen concentration. This six rights of medication administration also pertain to oxygen administration."</p>	{F 328}		

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{F 328}	Continued From page 8 On 12/18/14 at 3:50 PM the Administrator and DON were made aware of the concerns regarding oxygen. No further information was provided by the facility.	{F 328}			

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  MDS001800	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  R-C 12/18/2014
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{C 000}	<p>16.03.02 INITIAL COMMENTS</p> <p>The following deficiencies were cited during the followup to the annual state licensure and complaint survey of your facility.</p> <p>The surveyors conducting the survey were: Arnold Rosling, RN, QIDP Rebecca Thomas, RN</p> <p>The survey team entered the facility on December 17, 2014 and exited on December 18, 2014.</p>	{C 000}	<p style="text-align: center;">RECEIVED JAN - 5 2015 FACILITY STANDARDS</p> <p><b>C788</b></p> <p>See POC for F328</p> <p><b>Date of Compliance</b></p> <p>12/24/14</p>		
{C 788}	<p>02.200,03,b,iv Medications, Diet, Treatments as Ordered</p> <p>iv. Delivery of medications, diet and treatments as ordered by the attending physician, dentist or nurse practitioner; This Rule is not met as evidenced by: Refer to F328 as it relates to oxygen therapy.</p>	{C 788}		<p><b>C795</b></p> <p>See POC for F315</p> <p><b>Date of Compliance</b></p> <p>12/24/14</p>	
{C 795}	<p>02.200,03,b,xi Bowel/Bladder Evacuation/Retraining</p> <p>xi. Bowel and bladder evacuation and bowel and bladder retraining programs as indicated; This Rule is not met as evidenced by: Refer to F315 as it relates to the lack of a bladder evaluation.</p>	{C 795}			

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

*Jain Beatty*

TITLE

*Administrator*

(X6) DATE

*1/2/15*