



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

May 25, 2016

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

Provider #: 135129

Dear Mr. Lish:

On **May 13, 2016**, a 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 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. If applicable, a similar State Form will be provided 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." **Please provide ONLY ONE completion date for each federal and state tag (if applicable) 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.

Steve Lish, Administrator
May 25, 2016
Page 2 of

After each deficiency has been answered and dated, the administrator should sign the Form CMS-2567 and State Form (if applicable), Statement of Deficiencies and Plan of Correction in the spaces provided and return the original(s) to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **June 6, 2016**. Failure to submit an acceptable PoC by **June 6, 2016**, may result in the imposition of penalties by **June 30, 2016**.

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; and
- 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 the federal survey report, Form CMS-2567 and the state licensure survey report, State Form (if applicable).

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 **August 11, 2016 (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 **August 11, 2016**. A change in the seriousness of the deficiencies on **June 27, 2016**, may result in a change in the remedy.

Steve Lish, Administrator
May 25, 2016
Page 3 of

The remedy, which will be recommended if substantial compliance has not been achieved by **August 11, 2016** includes the following:

Denial of payment for new admissions effective **August 11, 2016**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying non-compliance, 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 **November 9, 2016**, 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, CMS will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact David Scott, R.N. or Nina Sanderson, L.S.W., 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 **August 11, 2016** 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 non-compliance 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>

Steve Lish, Administrator
May 25, 2016
Page 4 of

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 **June 6, 2016**. If your request for informal dispute resolution is received after **June 6, 2016**, 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 David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2.

Sincerely,

A handwritten signature in black ink that reads "D. Scott". The signature is written in a cursive style with a large initial "D" and a clear "Scott" following.

David Scott, Supervisor
Long Term Care

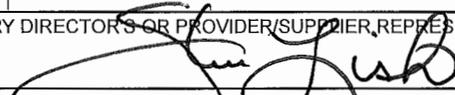
DS/pmt
Enclosures

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 05/13/2016
--	---	--	---

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 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the federal recertification survey of your facility conducted on-site from May 9, 2016 to May 13, 2016.</p> <p>The surveyors conducting the survey were: Linda Kelly, RN, Team Coordinator Nina Sanderson, LSW Teresa Kobza, RD, LD</p> <p>Abbreviations: ADL= Activities of Daily Living BBW = Black Box Warning CNA = Certified Nursing Assistant DON = Director of Nursing IDT = Interdisciplinary Team LPN = Licensed Practical Nurse LSW= Licensed Social Worker MAR = Medication Administration Record MDS= Minimum Data Set Assessment mg = Milligram(s) PO = By mouth RN = Registered Nurse UTI = Urinary Tract Infection w/c = Wheelchair XL or XR = Extended release</p>	F 000	<p>This Plan of Correction constitutes Discovery Care Center's written evidence of its achievement of substantial compliance relative to the Deficiencies (CMS-2567 dated 05/13/2016) and its ability to maintain substantial compliance through the monitoring of its quality assurance programs.</p> <p>The following Plan of Correction is submitted by the facility in accordance with the pertinent terms and provisions of 42 CFR Section 488 and/or related state regulations, and is intended to serve as a credible allegation of our intent to correct the practices alleged to be deficient. The Plan of Correction should not be construed or interpreted as an admission that the deficiencies alleged did, in fact, exist; rather, the facility is submitting this document in order to comply with its obligations as a provider participating in the Medicare/Medicaid program(s).</p>	
F 154 SS=D	<p>483.10(b)(3), 483.10(d)(2) INFORMED OF HEALTH STATUS, CARE, & TREATMENTS</p> <p>The resident has the right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition.</p> <p>The resident has the right to be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect</p>	F 154	<p style="text-align: center;"><i>RECEIVED</i></p> <p style="text-align: center;"><i>JUN - 7 2016</i></p> <p style="text-align: center;"><i>FACILITY STANDARDS</i></p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER/REPRESENTATIVE'S SIGNATURE 	TITLE Executive Director	(X6) DATE 06/05/16
--	------------------------------------	------------------------------

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.

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 05/13/2016
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 154	<p>Continued From page 1 the resident's well-being.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure 1 of 3 sample residents (#2) reviewed for depressive symptoms was informed of the risks and benefits, including BBW, of antidepressant medications, prior to initiation of the medications. The failure created the potential for more than minimal harm when Resident #2 was not given the opportunity to make an informed decision about the use of antidepressant medications before they were started. Findings include:</p> <p>Resident #2 was admitted to the facility in May 2013 with multiple diagnoses including dysthymic disorder (a form of depression).</p> <p>The annual and quarterly MDS assessments, dated 9/3/15 and 2/10/16 respectively, documented Resident #2 was mildly depressed.</p> <p>Resident #2's care plan documented antidepressant medication use as a focus area on 11/14/14, with revision on 4/25/16. Interventions included antidepressant medications as ordered, initiated on 11/14/14, and to encourage the resident to go to the dining room for meals and socialization daily, initiated on 4/25/16.</p> <p>A 1/29/16 Fax Consultation Form documented the physician ordered Wellbutrin XL 150 PO every day and to discontinue Effexor XR 75 mg in the evening on the fourth day.</p>	F 154	<p>Corrective Actions: Regarding resident #2, the antidepressant medication Prozac was reviewed with resident #2. Additionally, it was explained to resident #2, the medication was discontinued as of 04/12/16, which she is now on Effexor XR 75mg, and reviewed if resident #2 had any questions.</p> <p>Identification of others affected and corrective actions: Any resident that currently is prescribed an antidepressant and/or psychoactive medication may have been affected. Current residents that are prescribed a psychoactive will be evaluated for having signed consents, which is inclusive of the black box warnings.</p> <p>Measures to ensure that the deficient practice does not happen again: Nursing staff will be educated, that the system change will be at admission, the admitting nurse will review consents on psychoactive medications. On implementing new psychoactive medications, the medication will be placed on hold and the doctor notified, until the consent is reviewed with the resident or family.</p> <p>Monitor corrective actions: The DNS or designee will audit all new psychoactive medications for compliance with signed consents x 6 weeks and bring the results to QA monthly. Audits will begin 06/07/16</p>	06/17/16	

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

PRINTED: 05/24/2016
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 05/13/2016
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 154	<p>Continued From page 2</p> <p>Resident #2's Consent for treatment with Wellbutrin was signed on 2/4/16, or 6 days after Wellbutrin was initiated.</p> <p>A 3/15/16 verbal order documented the antidepressant was changed to Prozac 20 mg PO one time a day and Wellbutrin XL was discontinued.</p> <p>A consent for treatment with Prozac was not found in Resident #2's clinical record.</p> <p>A 4/12/16 verbal order documented the antidepressant was changed back to Effexor XR 75 mg PO in the evening and the Prozac was discontinued.</p> <p>Resident #2's Consent for treatment with Effexor was signed 5/12/16, or 1 month after the Effexor XR was initiated.</p> <p>On 5/12/16 at 4:15 pm, the DON said she did not find a consent for Resident #2's Prozac and the consents for Wellbutrin and Effexor XR were signed after both medications were started.</p>	F 154		
F 157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or</p>	F 157		

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 05/13/2016
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 157	<p>Continued From page 3</p> <p>clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to ensure the family of 1 of 10 (#3) sampled residents was notified of a change which impacted the resident's daily life. This resulted in a resident's family not being notified that the resident's hearing aid was lost. Findings include:</p> <p>Resident #3 was admitted to the facility 8/24/15 with diagnoses that included dementia. The resident also had hearing aids.</p> <p>On 8/31/15 the admission MDS assessment noted Resident #3 had difficulty hearing in some environments, such as when someone speaks</p>	F 157	<p>Corrective Actions: Resident #3, son was contacted by licensed social worker about the missing hearing aide. This was documented in a progress note.</p> <p>Identification of others affected and corrective actions: Any resident with hearing aids could have been affected. Current residents will be evaluated for any change which impacts the resident's daily life, and ensure that that family/representative has been notified.</p> <p>Measures to ensure that the deficient practice does not happen again: Staff education was provided on the systemic change of how referrals are to be sent to the licensed social worker for changes. Documentation will be placed in the form of a progress note into the electronic medical record, once completed. Additionally, the licensed social worker will follow up with the staff member who made the referral, as to the outcome.</p>		

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 05/13/2016
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 157	Continued From page 4 softly or the room is noisy. The MDS assessment also stated Resident #3 had a hearing aid device. On 10/20/15 Resident #3's MAR documented the left hearing aid was unable to be located. There were 66 subsequent notes documented from 10/21/15 to 12/4/15, which reported the missing hearing aid. A resolved Care Plan documented that Resident #3 had one hearing aid only and it was missing. The plan was to have social services contact Resident #3's family. On 12/4/15 a physician's order documented social services was notified of the missing hearing aid. There was no documentation that Resident #3's family was notified. On 5/12/16 at 5:00 pm, the MDS nurse and the LSW remembered the situation but could not find documentation that the family was notified.	F 157	Monitor corrective actions: Administrator or designee will audit referrals for 6 weeks for compliance of resident/family/representative notification. The audit results will be brought to QA monthly. Audits to begin 06/07/16	6/17/16	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure the dignity of 1 of 10 (#1) sampled residents residing in the facility. This resulted in the potential for a negative effect on the resident's	F 241	Corrective Actions: Discovery Care Center has purchased a privacy skirt for the shower chair, when it is in use for resident #1.		

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 05/13/2016
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 241	<p>Continued From page 5</p> <p>self-esteem and others' perceptions of the resident. Findings include:</p> <p>The Resident #1 was admitted to the facility on 1/29/16 with diagnoses which included a current UTI, a history of UTI's and a stage three pressure ulcer to the coccyx.</p> <p>On 4/29/16 Resident #1's most recent quarterly MDS documented she had an indwelling catheter.</p> <p>Resident #1's most recent Care Plan documented the catheter drain bag was to be placed in a black waterproof bag.</p> <p>On 5/10/16 at 10:04 am, Resident #1 was brought out of her room in a shower chair, covered with a towel and her dress. Her catheter bag was hanging from the chair on the left side. The catheter bag was not in the black bag and was visible to the residents sitting in chairs along the walls of the hall and in the day room.</p> <p>On 5/10/16 at 10:25 am, Resident #1 was brought out of the shower room fully covered with towels. The catheter bag was uncovered and visible to residents in the hall and the day room.</p> <p>On 5/12/16 at 5:07 pm, the DON stated it was not ok for the catheter bag to be uncovered.</p>	F 241	<p>Identification of others affected and corrective actions:</p> <p>Any resident with a catheter could have been affected. The purchase of a privacy skirt and in-servicing on providing resident dignity and ensuring that the resident catheter, etc. are not exposed will ensure that other resident's dignity is protected.</p> <p>Measures to ensure that the deficient practice does not happen again:</p> <p>Nursing staff will be in-serviced on the importance of maintaining dignity, while a resident is in the shower chair. The systematic change will be the provision of the privacy skirt for the shower chairs.</p> <p>Monitor corrective actions:</p> <p>DNS or designee will conduct a walk through audit 1 x per week for 6 weeks, evaluating for resident dignity, while bathing. The audit results will be brought to QA monthly. Audits will begin 06/07/16</p>	
F 246 SS=D	<p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES</p> <p>A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be</p>	F 246		6/17/16

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

PRINTED: 05/24/2016
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 05/13/2016
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 246	<p>Continued From page 6 endangered.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview, and record review, it was determined the facility failed to ensure the facility made accommodations necessary to meet the physical needs of 1 of 10 sample residents (#6). The failure created the potential for more than minimal harm if the resident experienced physical discomfort and/or decreased mobility due to use of a wheelchair that did not fit properly. Findings include:</p> <p>Resident #6 was admitted to the facility in February 2014 with multiple diagnoses including generalized muscle weakness and abnormalities of gait and mobility.</p> <p>The annual and quarterly MDS assessments, dated 9/2/15 and 3/3/16, documented Resident #6 had a severe cognitive impairment with a BIMS score of 6, required extensive 1 person assistance with ambulation in his room and on and off the unit, and used a walker and w/c.</p> <p>Resident #6's 9/2/15 annual MDS assessment documented he required limited 1 person assistance with ambulation in the hallways. His 3/3/16 quarterly MDS assessment noted he required extensive 1 person assistance with ambulation in hallways. The level of assistance Resident #6 required for ambulation increased between 9/2/15 and 3/3/16.</p> <p>Resident #6's care plan "to improve ambulation to</p>	F 246	<p>Corrective Actions: Resident #6, was placed in a wheelchair with a cushion ensuring proper placement with his feet flat on the floor.</p> <p>Identification of others affected and corrective actions:</p>		

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 05/13/2016
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 246	Continued From page 7 maximum self-sufficiency...", revised 12/7/15, included the intervention, "[U]tilize wheelchair for episodes of increased weakness with staff assist..." The ADL deficit care plan, also revised 12/7/15, included the intervention, "Using wheelchair with staff assist for episodes of increased weakness." On 5/10/16 at 7:50 am, 8:05 am, 8:35 am, and 8:58 am, and on 5/11/16 at 1:32 pm, Resident #6 was observed with his toes touching the floor and his heels suspended off the floor while in a w/c with a 3 inch seat cushion. He was unable to place his feet flat on the floor when he was in the w/c. On 5/11/16 at 1:35 pm, RN #1 said Resident #6 previously had a w/c that fit him and he was able to use his feet to propel the w/c. RN #1 said the w/c he currently used was not his. RN #1 radioed other staff and asked if they knew the whereabouts of Resident #6's previous w/c. On 5/11/16 at 2:05 pm, RN #1 said she could not find Resident #6's previous w/c and that they would add foot pedals to the current w/c until they could get another w/c to fit the resident. CNA #3, who was present, said the facility had recently replaced several wheelchairs and the resident's previous w/c may have been one of them. On 5/11/16 at 5:10 pm, LPN #1 was observed as she assisted Resident #6 to transfer to a w/c with a 2 inch air bubble type seat cushion. He was able to place both feet flat on the floor. Resident #6 said the w/c "Feels better."	F 246	Any resident could have been affected. Current residents will be evaluated for appropriate positioning while in their wheelchair. Measures to ensure that the deficient practice does not happen again: Staff training was completed for nursing staff, therapy and central supply for appropriate wheelchair positioning while the resident is sitting in it. Systematic change will be that residents are re-assessed for proper positioning quarterly and as needed for a change of condition. Monitor corrective actions: Therapy or designee will audit wheelchair positioning for 6 weeks. The audit results will be brought to QA monthly. Audits will begin 06/07/16 <i>Per telephone conversation with Steve Lish (Admin) on 6/16/16 @ 2:10 pm - Audits for all residents using wheelchairs will take place once per week for six weeks, completed by a therapist or designee.</i> <i>Nina Soudilova</i>	6/17/16	
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE	F 250			

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 05/13/2016
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 250	<p>Continued From page 8</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility failed to ensure resources or referrals were provided to assist 1 of 10 (#3) sampled residents. This failure created the potential for harm if the resident was unable to effectively communicate with those around her. Findings include:</p> <p>Resident #3 was admitted on 8/24/15 with diagnoses which included dementia. Resident #3 had a left hearing aid upon admit.</p> <p>On 8/31/15, the admission MDS assessment documented Resident #3 had difficulty hearing in some environments, such as when someone speaks softly or the room is noisy. The MDS assessment also noted Resident #3 had a hearing aid device.</p> <p>On 10/20/15, the MAR documented the left hearing aid was unable to be located. There were 66 subsequent notes documented from 10/21/15 to 12/4/15, which reported the hearing aid missing.</p> <p>Resident #3's Care Plan documented that Resident #3 had one hearing aid only and it was missing. The plan was to have social services contact the resident's family. The care plan</p>	F 250	<p>Corrective Actions: Staff education was provided on how referrals are to be sent to the licensed social worker for changes with regard to resident #3.</p> <p>Identification of others affected and corrective actions: Any resident could have been affected. Current residents will be evaluated for any change which impacts the resident's daily life, and ensure that the licensed social worker has been notified</p> <p>Measures to ensure that the deficient practice does not happen again: Staff education was provided on the systemic change how referrals are to be sent to the licensed social worker for changes. Once received and acted upon, the licensed social worker will follow up with the staff member who made the referral, as to the outcome.</p> <p>Monitor corrective actions: Administrator or designee will audit for changes that have occurred for 6 weeks for compliance of referral to licensed social worker. The audit results will be brought to QA monthly. Audits will begin 06/07/16</p>	6/17/16	

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

PRINTED: 05/24/2016
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 05/13/2016
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 250	Continued From page 9 showed the issue was resolved on 12/4/15. On 12/4/15, a physician's order documented "We were putting hearing aid on med cart at night - 1 She has lost her hearing aid so we need to D/C this order." The order also documented social services was notified of the missing hearing aid on 12/4/15. On 5/12/16 at 5:00 pm, the MDS nurse and the LSW stated they remembered the situation and that Resident #3 did not have the hearing aid to use since it was lost. The LSW and the MDS nurse could not find documentation of an investigation into the missing hearing aids or referrals to her doctor for an assessment of her hearing needs.	F 250			
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format.	F 356			

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 05/13/2016
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 356	<p>Continued From page 10</p> <p>o In a prominent place readily accessible to residents and visitors.</p> <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure the nurse staffing information was prominently posted in a location readily accessible to residents and visitors. The failure had the potential to affect 9 of 9 sample residents (#s 1-9), all other residents who lived in the facility, and visitors to the facility. Findings include:</p> <p>The nurse staffing information was observed in a non-resident area on 5/9/16 at 5:00 pm, 5/10/16 at 8:52 am, and 5/11/16 at 8:45 am. The nursing hours information was posted on a cork board on the wall above a 48 inch tall bookcase across from the end of the counter at the nurses' station and next to the DON's office. In addition, 3 caddies full of medical equipment and a gait belt on the top shelf of the bookcase obstructed the view of the posted information.</p> <p>On 5/11/16 at 8:45 am, LPN #2 said residents in wheelchairs would not be able to see the nursing hours information where it was posted. The Administrator was present at the time and he</p>	F 356	<p>Corrective Actions: The nurse staffing information has been relocated and posted to an area that is visible to residents and visitors, and at a height that is noticeable to a resident in a wheelchair.</p> <p>Identification of others affected and corrective actions: Any resident could have been affected. The nurse staffing information is now posted in a visible location to all residents/visitors.</p> <p>Measures to ensure that the deficient practice does not happen again: The measures and systemic changes are nurse staff will be in-serviced on the regulation requirement and where this information is to be posted.</p> <p>Monitor corrective actions: DNS or designee will conduct a walk through audit 1 x per week for 6 weeks, evaluating for proper placement of posting of nurse staff hours. The audit results will be brought to QA monthly. Audits will begin 06/07/16</p>	6/17/16	

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

PRINTED: 05/24/2016
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 05/13/2016
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 356	Continued From page 11 instructed LPN #2 to move the nursing hours information to a resident area.	F 356		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview it was determined the facility failed to ensure complete and accurate medical records were maintained for each resident. This was true for 1 of 10 (#1) sampled residents. This failed practice created the potential for harm if decisions were made based on incomplete or inaccurate information. Findings include: Resident #1 was admitted to the facility on 1/29/16 with diagnoses which included a current UTI, a history of UTI's and a stage two pressure ulcer to the coccyx. On 1/29/16 Resident #1's Admission Nursing Assessment documented she had a stage two	F 514		

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 05/13/2016
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)
F 514	<p>Continued From page 12</p> <p>pressure ulcer to her coccyx. Resident #1's recapitulation orders for May 2016 documented she had a stage two pressure ulcer.</p> <p>On 2/5/16 the MDS assessment documented Resident #1 had a stage three pressure ulcer on her coccyx.</p> <p>On 2/5/16 Resident #1's nursing progress note documented she had a stage three pressure ulcer.</p> <p>The physician's recapitulation orders documented a stage two wound. The MD and progress notes documented a stage three wound.</p> <p>On 5/12/16 at 5:32 pm, the DON stated when a resident is admitted to the facility with a wound, the admission nurse is to assess and document the wound size and characteristics. The DON said only she or the wound nurse could stage a wound. She said the wound nurse assessed the wound to be a stage three, based on her assessment and the characteristics charted by the nurse at the time of admission. The DON stated the physician's recapitulation orders should have been updated to accurately reflect the wound as a stage three.</p>	F 514	<p>Corrective Actions:</p> <p>On admission only the Wound Nurse and the Director of Nursing are to stage a pressure ulcer. A one to one in-service was completed with the nurse who admitted resident #1, regarding the system of wound staging at Discovery Care Center. Additionally, Medical Records and Nurses will be in-serviced about consulting with the IDT team for insuring proper diagnosis are placed on the recapitulation of physician orders.</p> <p>Identification of others affected and corrective actions:</p> <p>Any current resident could have been affected, that were identified at admission as having a pressure ulcer. Current residents identified with a pressure ulcer will be reviewed for accuracy, and placed in an IDT note.</p> <p>Measures to ensure that the deficient practice does not happen again:</p> <p>Nurse staff will be in-serviced on the system of wound staging at Discovery Care Center. Additionally, nursing staff will be in-serviced about pressure ulcer protocol for preventative measures. The DNS and the wound nurse will review the National Pressure Ulcer Advisory Panels definitions for pressure ulcers.</p> <p>Monitor corrective actions:</p> <p>DNS or designee will audit all pressure ulcer documentation for 6 weeks. The audit results will be brought to QA monthly. Audits will begin 06/07/16</p>

6/17/16

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 05/13/2016
--	--	---	---

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 000	<p>16.03.02 INITIAL COMMENTS</p> <p>The following deficiencies were cited during the state licensure survey between 5/9/16 and 5/13/16.</p> <p>The team members conducting the survey were:</p> <p>Linda Kelly, RN, Team Coordinator Nina Sanderson, LSW Teresa Kobza, RD, LD</p>	C 000	<p style="text-align: center;"><i>RECEIVED</i> <i>JUN - 7 2016</i> <i>FACILITY STANDARDS</i></p>	
C 422	<p>02.120.05,p,vii Capacity Requirments for Toilets/Bath Areas</p> <p>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.</p> <p>This Rule is not met as evidenced by: Based on observation and staff interviews, it was determined the facility failed to maintain the minimum number of bathing facilities for the number of licensed beds. This affected 9 of 9 (#s 1-9) sampled residents residing in the facility 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 5/12/16 at 3:00 pm, the Bathing Room was observed with one bathtub and one shower stall</p>	C 422	<p>On each patient/resident floor or nursing unit there shall be at least one (1) tub or shower for every twelve (12) licensed beds. It was determined that the facility failed to maintain the minimum number of bathing facilities for the number of licensed beds.</p> <p>A request for a "waiver" was made. 05/31/16</p>	6/17/16

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

TITLE

(X6) DATE

Executive Director 06/05/16

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 05/13/2016
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	Continued From page 1 in usable condition for residents. The Administrator stated he was aware the facility did not have the required number of bathing facilities for the number of licensed beds. The Administrator stated the facility had historically been granted a waiver for this requirement, as the number of bathing facilities was sufficient to meet resident bathing needs and preferences, and the facility planned to request a waiver again. Individual and group resident interviews and resident family interviews conducted throughout the survey revealed no difficulties with residents receiving baths or showers. No concerns with resident bathing were identified through resident reviews.	C 422		