



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor  
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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](mailto:fsb@dhw.idaho.gov)

August 11, 2016

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

Provider #: 135104

Dear Ms. Bentzler:

On **July 28, 2016**, a survey was conducted at Twin Falls 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.

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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 **August 22, 2016**. Failure to submit an acceptable PoC by **August 22, 2016**, may result in the imposition of penalties by **September 15, 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 **September 1, 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 **October 26, 2016**. A change in the seriousness of the deficiencies on **September 11, 2016**, may

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result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **October 26, 2016** includes the following:

Denial of payment for new admissions effective **October 26, 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 **January 24, 2017**, 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 **October 26, 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:

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<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 **August 22, 2016**. If your request for informal dispute resolution is received after **August 22, 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.

David Scott, RN, Supervisor  
Long Term Care

DS/lj  
Enclosures

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

PRINTED: 09/19/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135104</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/28/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>TWIN FALLS CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>674 EASTLAND DRIVE TWIN FALLS, ID 83301</b>		
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F 000	<p><b>INITIAL COMMENTS</b></p> <p>The following deficiencies were cited during the federal recertification and complaint survey conducted at the facility July 25, 2016 to July 28, 2016.</p> <p>The surveyors conducting the survey were: Amy Barkley, RN, BSN, Team Coordinator Jennifer McCants, MS, RD, LN Amy Youngman, RN, ND, NHA Patricia Kurywka, RN Patricia McMahon, RN</p> <p>Survey definitions:</p> <p>A1C = The A1C test is a blood test that provides information about a person's average levels of blood glucose, also called blood sugar, over the past 3 months. ADL = Activities of Daily Living CBC = Complete Blood Count (a blood test used to evaluate your overall health and detect a wide range of disorders) CNA = Certified Nurse Assistant COPD = Chronic Obstructive Pulmonary Disease COTA = Certified Occupational Therapy Assistant CPR = Cardiopulmonary Resuscitation CVA = Cerebrovascular Accident (stroke) DON = Director of Nursing lbs = pounds LN = Licensed Nurse LPN = Licensed Practical Nurse MAR = Medication Administration Record ml = milliliter OT = Occupational Therapy SBAR = Situation, Background Assessment, Review</p>	F 000			
F 155	483.10(b)(4) RIGHT TO REFUSE; FORMULATE	F 155		9/9/16	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

08/19/2016

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 155 SS=D	<p>Continued From page 1 ADVANCE DIRECTIVES</p> <p>The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section.</p> <p>The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure the Advanced Directives for 2 of 24 sampled residents (#6 and #7) agreed with the residents' physician orders and/or care plans. The deficient practice had the potential to cause more than minimal harm if the residents were to have treatment either withheld or provided contrary to their documented wishes. Findings include:</p> <p>1. Resident #7 was admitted to the facility on 7/5/16 with diagnoses including history of knee</p>	F 155	<p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Twin Falls Center does not admit that the deficiencies listed on this form exist, nor does the Center admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Center reserves the right to challenge in legal and/or administrative proceedings the deficiencies, statements, facts and conclusions that form the basis</p>		

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F 155	<p>Continued From page 2 replacement and chronic pain.</p> <p>Resident #7's Admission MDS assessment, dated 7/15/16, documented Resident #7 was cognitively intact and able to make all of her own decisions regarding care.</p> <p>Resident #7's Idaho Physician Orders for Scope of Treatment (POST) form, signed by Resident #7 and dated 6/27/16, documented she wished to be a Full Code (CPR to be performed in the event resident was found not breathing and/or without a heartbeat).</p> <p>Resident #7's Physician Orders, dated 7/2016, documented her code status was DNR.</p> <p>Resident #7's Advanced Directives Care Plan, dated 6/28/16, documented her Advanced Directive was DNR and that staff was to activate her advanced directive as indicated.</p> <p>Resident #7's MARs for 7/2016 documented her Advanced Directive was DNR.</p> <p>On 7/26/16 at approximately 2:45 pm, the DON confirmed Resident #7's Physician Orders, MAR, and Care Plan were incorrect, as Resident #7's Advanced Directive status was a Full Code, and the documentation needed to be fixed immediately.</p> <p>2. Resident #6 was admitted to the facility on 6/29/16 with diagnoses including acute kidney failure, malnutrition, and chronic pain.</p> <p>Resident #6's admission MDS assessment, dated 7/5/16, documented she was cognitively</p>	F 155	<p>for the deficiencies.</p> <p>F155</p> <p>Specific Residents Identified Resident #7 was assessed by the Nurse Unit Manager on 7/26/16 for any adverse effects related to advance directives and incorrect physician orders, MAR, and care plan; no adverse effects noted. The physician orders, MAR, and care plan were revised and corrected by the Nurse Unit Manager on 7/26/16 to reflect the resident wishes as per her completed POST form. The advanced directive, physician orders, MAR, and care plan were again reviewed by the RN Shift Supervisor on 8/13/16 for accuracy, no changes needed at that time.</p> <p>Resident #6 was assessed by the Nurse Unit Manager on 7/26/16 for any adverse effects related to advance directives and incorrect care plan; no adverse effects noted. The care plan was revised and corrected by the Nurse Unit Manager on 7/26/16 to reflect the resident wishes as per her completed POST form. The resident discharged from the facility on 7/30/16.</p> <p>Identification of Other Residents Residents with advanced directives were reviewed by the Center Nurse Executive and RN Shift Supervisor on 8/13/16 &amp; 8/14/16. Any residents identified as having incomplete advance directives, inaccurate MD orders, inaccurate MAR</p>		

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F 155	<p>Continued From page 3 intact and able to make all of her own decisions regarding care.</p> <p>Resident #6's 7/4/16 POST form was signed by the resident and documented her desired code status was Full Code.</p> <p>Resident #6's Physician Orders and MAR, dated 7/2016, both correctly documented Resident #6's code status was Full Code.</p> <p>Resident #6's Advanced Directives Care Plan, dated 6/28/16, documented her code status as "DNR."</p> <p>On 7/26/16 at approximately 2:45 pm, the DON confirmed Resident #6's care plan was incorrect, as Resident #6's Advanced Directive status was a Full Code, and the documentation needed to be fixed immediately.</p>	F 155	<p>documentation, or inaccurate care plans were assessed for adverse effects related to advance directive discrepancies; no adverse effects noted. Corrections to resolve the discrepancies on the identified residents were completed before 8/18/16.</p> <p><b>Systemic Changes</b> Facility staff have been educated by the Center Nurse Executive or designee on or before 8/31/16 regarding advance directives and accurate MD orders, MAR documentation, and care plans. The facility will begin reviewing resident advance directives including MD orders, MAR documentation, and care plans for accuracy during morning clinical meeting for new residents and for changes in resident advance directives beginning 8/31/16.</p> <p><b>Monitoring</b> Starting the week of 9/1/16, an advance directive audit of 5 residents will be completed by the Center Nurse Executive or designee weekly x 4 weeks and then monthly x 2 months to ensure resident advance directives are accurately reflective on MD orders, MAR documentation, and care plans. The results of those audits will be reported to the Performance Improvement Committee for three months for review and follow up intervention. The Center Nurse Executive is responsible for compliance and monitoring. The Performance Improvement Committee will re- evaluate the need for further monitoring after 3</p>		

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F 155	Continued From page 4	F 155	months.		
F 157 SS=E	<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 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>	F 157	Date of Compliance 9/9/16	9/9/16	

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F 157	<p>Continued From page 5</p> <p>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 physician was notified of residents' high blood glucose (blood sugar) levels in accordance with physician prescribed notification parameters. This was true for 4 of 24 sampled residents (#2, #16, #18, and # 19). This created the potential for more than minimal harm if a resident's physician was not informed of BG readings that could necessitate a change in the resident's diabetic management regimen. Findings include:</p> <p>1. Resident #2 was admitted to the facility on 2/15/13 with diagnosis of Type II diabetes mellitus. Resident #2's 4/26/16 MDS assessment documented she required assistance with eating, was edentulous, and wreceived a mechanically altered diet. The 4/26/16 MDS assessment documented Resident #2 received insulin all 7 days in the assessment period.</p> <p>During the survey from 7/25/16 to 7/28/16, Resident #2 was observed to be dependent on staff for meals and had periods of sleepiness. Resident #2 was observed at breakfast on 7/26/16 from 8:20 amto 9:00 amShe did not initiate eating independently, and staff were observed to feed her. Resident #2's head was slumped forward and her eyes were closed during the meal when she was not actively being fed by the staff member. Resident #2's tray card documented she was on a consistent carbohydrate diet.</p>	F 157	<p>F157</p> <p>Specific Residents Identified Resident #2 was assessed by the Nurse Unit Manager on 7/27/16 for any adverse effects related to physician notification regarding blood sugars readings; no adverse effects noted. The physician was notified on 7/27/16 of the resident blood sugar readings and reviewed the record, order changes were implemented. Resident #2 diabetic management and resident specific goals will be reviewed on or before 8/31/16 with follow up as indicated.</p> <p>Resident #16 was assessed by the Nurse Unit Manager on 7/27/16 for any adverse effects related to physician notification regarding blood sugars readings; no adverse effects noted. The physician was notified on 7/27/16 of the resident blood sugar readings and reviewed the record, order changes were implemented. Resident #16 diabetic management and resident specific goals will be reviewed on or before 8/31/16 with follow up as indicated.</p> <p>Resident #18 was discharged from the facility on 8/6/16.</p> <p>Resident #19 was discharged from the facility on 8/3/16.</p>		

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F 157	<p>Continued From page 6</p> <p>Resident #2's physician was interviewed on 7/28/16 at 9:23 am. The physician stated Resident #2 had a recent period of medical instability corresponding with significant weight loss and a change in condition. Resident #2's BG was both low and high and multiple changes were made to her insulin and diabetic regimen. The physician stated he was notified by nursing staff a number of times of both high and low blood sugars.</p> <p>Physician's Orders, dated 12/30/15, directed nursing staff to notify the physician for any two BG readings greater than 250 with an associated change in condition during all or part of two consecutive days, or two BG readings greater than 300 during all or part of 2 consecutive days, or any one BG reading greater than 400 as needed for diabetic management.</p> <p>Resident #2's BG levels were to be checked 3 times a day at 7:00 am, 12:00 pm, and 5:00 pm with sliding scale parameters in place to address hypoglycemia (low blood glucose) and hyperglycemia (high blood glucose).</p> <p>Current insulin orders, dated 7/7/16, documented: Humalog solution (insulin) 100 unit/ml 4 units with meals and Humalog solution 100 unit/ml per sliding scale of:</p> <p>0-150 = 0 units; 151-200 = 2 units; 201-250 =4 units; 251-300 = 6 units; 301-350 = 8 units; 351-400 = 10 units; if greater than 401, give 15 units and recheck BG</p>	F 157	<p>Identification of Other Residents A review of residents with parameters for physician notification regarding blood sugar readings will be completed by the Center Nurse Executive and Nurse Unit Managers on or before 8/31/16 Residents identified as having met criteria for physician notification in the last 30 days were reviewed for physician notification according to physician parameters and follow up with any order changes will be implemented at the time of the review.</p> <p>Systemic Changes Licensed nurses will be educated by the Center Nurse Executive or designee on or before 8/31/16 regarding notification to physician as per ordered parameters for blood sugar readings. The facility will begin reviewing insulin dependent residents during the morning clinical meeting after admission to ensure the parameters for physician notification of blood sugar readings correspond with the resident specific goals for diabetic management. The facility will continue to implement protocol parameters if no resident specific parameters are identified.</p> <p>Nursing staff were re educated on or before 9/9/16 by the Center Nurse Executive or designee on diabetic management system and safe insulin administration, documentation and physician notification. Beginning on or before 9/9/16, nurses will update the 24 hour report for resident's who have blood</p>		

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F 157	<p>Continued From page 7 in 2 hours.</p> <p>SBAR Communication forms, Nurses' Notes, and Physician's Progress Notes were reviewed. Resident #2's physician was not notified of her high BG levels 4 times over the previous 5-week period:</p> <p>* 6/12/16: Resident #2's BG level at 12:00 pm was 311; BG level at 5:00 pm was 337. The physician was not notified of BG levels meeting the notification parameter of 2 BG readings greater than 300 within all or part of 2 consecutive days.</p> <p>* 6/22/16: Resident #2's BG level at 7:00 am was 345; BG level at 5:00 pm was 398. The physician was not notified of the BG levels meeting the notification parameter of 2 BG readings greater than 300 within all or part of 2 consecutive days.</p> <p>* 7/1/16: Resident #2's BG level at 7:00 am was 315; BG level at 12:00 pm was 301; BG level at 5:00 pm was 313. The physician was not notified of BG levels meeting the notification parameter of 2 BG readings greater than 300 within all or part of 2 consecutive days.</p> <p>* 7/5/16: Resident #2's BG level was 349 at 12:00 pm; BG level at 5:00 pm was 346. The physician was not notified of BG levels meeting the notification parameter of 2 BG readings greater than 300 within all or part of 2 consecutive days.</p> <p>On 7/28/16 at 2:00 pm, the DON stated she researched Resident #2's medical record and was unable to find verification of physician</p>	F 157	<p>sugars outside of their physician ordered parameter or who require that insulin be held.</p> <p>Monitoring Starting the week of 9/10/16, a physician notification audit of 5 residents will be completed daily by the Center Nurse Executive or designee x 3 weeks and then weekly for 4 weeks and monthly x 2 months to ensure resident's physicians are being notified according to parameters for blood sugar readings. The results of those audits will be reported to the Performance Improvement Committee for four months for review and follow up intervention. The Center Nurse Executive is responsible for compliance and monitoring. The Performance Improvement Committee will re- evaluate the need for further monitoring after 4 months.</p> <p>Date of Compliance 9/9/16</p>		

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F 157	<p>Continued From page 8 notification on 6/12/16, 6/22/16, 7/1/16 and 7/5/16.</p> <p>2. Resident #16 was admitted to the facility on 6/21/16 with diagnoses including Type II diabetes.</p> <p>Resident #16's admission MDS assessment, dated 6/30/16 documented she received daily insulin injections during the assessment reference period.</p> <p>Resident #16's Diabetes Care Plan, dated 6/21/16, documented she was insulin dependent and staff was to monitor for signs and symptoms of hyper/hypoglycemia (high/low BG level), report abnormal findings to the physician, and administer medication as ordered.</p> <p>Resident #16's Physician Orders, dated 7/15/16, documented she was to have her BG checked four times daily (before meals and at bedtime) and was to receive Novolog Solution (insulin) 100 units per milliliter via sliding scale orders as follows:</p> <p>0 units for BG of 71-149 2 units for BG of 150-199 4 units for BG of 200-249 6 units for BG of 250-299 8 units for BG of 300-349 10 units for BG of 350-399</p> <p>Nursing was to notify the physician for BG less than 70; for BG greater than 250 with an associated change of condition during all or part of two consecutive days; or for two BG readings greater than 300 during all or part of two</p>	F 157			

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F 157	<p>Continued From page 9 consecutive days; or any one reading above 400.</p> <p>Resident #16's MAR dated 7/16/16, documented the following BG readings above 300:</p> <ul style="list-style-type: none"> <li>* 7/1/16 at 11:00 am was 392</li> <li>* 7/2/16 at 11:00 am was 358, 4 pm was 407, and bedtime was 395</li> <li>* 7/3/16 at 11:00 am was 303, 4:00 pm was 350, and bedtime was 399</li> <li>* 7/4/16 at 4:00 pm was 320, and bedtime was 353</li> <li>* 7/5/16 at bedtime was 393</li> <li>* 7/6/16 at bedtime was 367</li> <li>* 7/7/16 at 4:00 pm was 302</li> <li>* 7/10/16 at 11:00 am was 304</li> <li>* 7/11/16 at bedtime was 323</li> <li>* 7/14/16 at bedtime was 344</li> <li>* 7/17/16 at 11:00 am was 351 and 4:00 pm was 330</li> <li>* 7/20/16 at 11:00 am was 378</li> <li>* 7/26/16 at bedtime was 300.</li> </ul> <p>Resident #16's Progress Notes and Change of Condition documentation for 7/15/16 documented Resident #16's physician was notified of the 7/2/16 BG level of 407. Nothing further could be found in the documentation to indicate Resident #16's physician was notified of other BG readings greater than 300 during the month of July.</p> <p>On 7/27/17 at 3:45 pm, LPN #18 stated the BG orders for all residents in the facility were complicated. She stated she would be looking over the previous day's BG readings (7/26/16) for residents in her care that day (7/27/16 ) because the orders were so complicated that she did not</p>	F 157			

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F 157	<p>Continued From page 10 have time to review readings for the parameters each day. She stated, "The process is time consuming and confusing."</p> <p>On 7/28/16 at approximately 9:00 am, the DON confirmed the lack of documentation to verify Resident #16's physician was notified of high BG levels per physician's orders, although she felt Resident #16's physician was generally aware of her condition since he rounded in the facility 5 to 6 mornings per week.</p> <p>On 7/28/16 at 9:15 am, Resident #16's physician stated he was generally aware of Resident #16's high BG readings, and that he expected her readings to be high since she had been ill recently and was taking prednisone (an anti-inflammatory steroid). He stated he felt he had most likely been notified of most of Resident #16's high BG readings, but that he did not have documentation to support that, and did not know specifically which readings he had/had not been notified of.</p> <p>3. Resident #18 was admitted to the facility on 3/15/16 with diagnosis of diabetes mellitus.</p> <p>Resident #18's Physician Orders, with a start date of 6/24/16, documented the resident was to receive Novolog Solution, 100 units/ml, before meals and at bedtime, inject per sliding scale:</p> <p>0 units for BG of 71-149 2 units for BG of 150-199 4 units for BG of 200-249 6 units for BG of 250-299 8 units for BG of 300-349 10 units for BG of 350-399</p>	F 157			

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F 157	<p>Continued From page 11</p> <p>Nursing was to notify the physician for BG less than 70; for BG greater than 250 with an associated change of condition during all or part of two consecutive days; or for two BG readings greater than 300 during all or part of two consecutive days; or any one reading above 400.</p> <p>Resident #18's MAR for July 2016 included the following BG levels greater than 300:</p> <p>7/17/16 at 9:00 pm the BG level was 330 7/18/16 at 5:00 pm the BG level was 338 7/21/16 at 5:00 pm the BG level was 364.</p> <p>There was no documentation in Resident #18's record that the physician was notified of the above BG readings over 300.</p> <p>On 7/8/16 at approximately 2:00 pm, the Medication Nurse stated the physician should have been notified per the orders written on the MAR.</p> <p>4. Resident #19 was admitted to the facility with multiple diagnoses including Type II diabetes mellitus insulin dependence.</p> <p>Physician Orders dated July 2016 directed nursing staff to notify the physician for any two BG readings greater than 250 with an associated change in condition during all or part of two consecutive days, or two BG readings greater than 300 during all or part of 2 consecutive days, or any one BG reading greater than 400.</p>	F 157			

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F 157	Continued From page 12 Resident #19's July 2016 MAR documented that on 7/23/16, 7/24/16, and 7/25/16, Resident #19's BG levels ranged from 312 - 342. These BG levels required physician notification as they matched the notification parameter of two BG readings greater than 300 during all or part of 2 consecutive days.  Nurses' Notes, Physician Notes, and SBAR Communication forms, reviewed from 7/24/16 to 7/26/16, did not include documentation that Resident #19's physician was notified of her elevated BG readings noted above.  On 7/28/16 at 9:00 am, the DNS stated she did not have written documentation the MD was notified of Resident #19's BG levels above 300 from 7/24/16 to 7/26/16. The DNS stated Resident #19's physician came to the facility 5-6 times a week and was notified verbally of any BG levels outside of the identified parameters. The DNS stated LNs were not documenting in the nurses' notes, or on the SBAR communication form, each time they notified the physician of elevated blood glucose levels.  On 7/28/16 at 9:15 am, when asked if he had been notified of BG levels outside of the parameters for Resident #19, the resident's physician stated the facility would notify him via telephone or verbally when he visited the facility 5-6 days a week. The physician stated he did not document a note each time the facility notified him about elevated blood glucose levels.	F 157			
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY  The facility must promote care for residents in a	F 241		9/9/16	

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F 241	<p>Continued From page 13</p> <p>manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure residents were treated with dignity and respect during their dining experience. This was true for 2 of 9 residents (#2 &amp; #8) sampled during meal time. Failure to promote the residents' dignity in dining created the potential for a negative effect on the residents' psychosocial well-being and provide insufficient time and desire to eat. Findings include:</p> <p>1. Resident #2 was admitted to the facility on 2/15/13 with diagnosis of Type II diabetes mellitus. Resident #2's 4/26/16 MDS assessment documented she required assistance with eating, was edentulous and received a mechanically altered diet.</p> <p>During the breakfast meal on 7/26/16, Resident #2 did not initiate eating independently and was observed to be dependent on staff to eat. Resident #2 was observed waiting an extended amount of time at the table for food, beverages, and for assistance with the meal, while residents in the main dining room (that adjoined the area for residents requiring assistance) were served their meals starting at 8:05 am and their beverages prior to that. Meal service was not dignified as Resident #2 waited an extended time to be served and assisted with the meal while residents in the main dining area were served</p>	F 241	<p>F241</p> <p>Specific Residents Identified</p> <p>Residents #2 and #8 will be assessed for signs and symptoms of adverse effects post incident by the Center Nurse Executive on or before 8/31/16. Any findings will be addressed and corrected by the Center Nurse Executive or designee on or before 8/31/16.</p> <p>Identification of Other Residents</p> <p>Observations of all three meals will be completed by the Executive Director or designee on or before 8/31/16 to ensure that residents in the assisted dining room are served beverages and meals at the same time as the residents in the main dining room and provided assistance with their meals. Identified concerns will be addressed and corrected by the Center Nurse Executive or designee on or before 8/31/16.</p> <p>Systemic Changes</p> <p>A licensed nurse will be assigned to supervise and assist with serving beverages and meals in the dining room</p>		

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F 241	<p>Continued From page 14</p> <p>beverages, their meals promptly, and provided with assistance such as getting additional foods, helping with application of condiments, and preparing their meals. Observations included:</p> <p>* Resident #2 was brought to the assisted dining area in her wheelchair at 8:20 am. Nine residents were seated in the assisted dining area when she arrived. None of the residents in the assisted area had beverages or food at their places. There were a number of staff in the main dining area serving and assisting residents with their meals. There were no staff present in the assisted area. Resident #2 sat in the wheelchair with her head slumped forward and eyes closed, without any food or beverages for 18 minutes, until 8:38 am.</p> <p>* Resident #2 was served her meal consisting of pancakes with syrup, sausage, and oatmeal at 8:38 am. The uncovered plate remained in front of her while she continued to sit with her head slumped forward and eyes closed.</p> <p>* At 8:39 am. Resident #2 was served a glass of orange juice; no staff came to assist her eat until 8:44 am, 24 minutes after arriving in the dining room and 6 minutes after her tray was served.</p> <p>* At 8:44 am, most residents in the main dining area were finished eating and starting to depart the dining room. A CNA began to feed Resident #2 and a second resident sitting adjacent to Resident #2.</p> <p>* Resident #2 was provided with intermittent (CNA feeding 2 residents) meal assistance from 8:44 am until 8:58 am. Approximately 7 minutes</p>	F 241	<p>15 minutes prior to and for the first 15 minutes of meal service for each meal on or before 8/31/16 to ensure that the residents in the assisted dining room are served drinks and meals at the same time as the residents in the main dining room and provided assistance with their meals. Facility staff educated on this change by the Executive Director or designee on or before 8/31/16. The licensed social worker will educate nursing staff on or before 8/31/16 regarding residents' dignity during dining.</p> <p>Monitoring</p> <p>Starting the week of 9/1/16, audits will be completed of beverage and meal service 3 times a week x 4 weeks and weekly x 2 months by the Executive Director or designee to ensure that residents who eat in the assisted dining room are served at the same time as residents in the main dining room and provided assistance with their meals. Results of the audits will be reported to the Performance Improvement Committee for three months for review and follow up intervention. The Performance Improvement Committee will re- evaluate the need for further monitoring after 3 months. Changes in the dining service will be reviewed during Resident Council meetings for three months for resident follow up. The Executive Director is responsible for</p>		

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F 241	<p>Continued From page 15</p> <p>total assistance (half of 14-minute total timeframe to assist 2 residents) was provided to Resident #2. She ate less than 25% of her meal.</p> <p>LPN #5 was interviewed on 7/26/16 at 11:00 a.m. and verified Resident #2 required assistance with activities of daily living including eating. LPN #5 stated Resident #2 required 1-person assistance with meals.</p> <p>The Dietitian was interviewed on 7/28/16 at 10:00 am and stated Resident #2 was a light eater, picky, and selective regarding what foods she ate.</p> <p>The Dietary Manager was interviewed on 7/28/16 at 9:15 am and stated that residents in the assisted area were to be served drinks and their meals at the same time as residents in the main dining room and not after all residents in the main dining area were served.</p> <p>2. Resident #8 was admitted to the facility on 10/13/15 with diagnoses of Cerebral Vascular Accident (CVA) and dysphagia. Resident #8's MDS assessment, dated 4/17/16, documented Resident #8 required moderate assistance of one staff for eating.</p> <p>In the main dining room on 7/26/16 at 8:35 am, Resident #8 was observed seated in her recliner at the table. CNA #1 delivered Resident #8's food, left the uncovered tray in front of her, and proceeded to pass more food trays. Resident #8's food remained uncovered while she dozed in her recliner. At 8:50 am, CNA #18 started talking to Resident #8, cut her food, and fed her.</p>	F 241	<p>compliance and monitoring.</p> <p>Date of Compliance</p> <p>9/9/16</p>		

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F 241	Continued From page 16 On 7/26/16, CNA #1 stated she left the food uncovered because CNA #18 was going to assist Resident #8 with eating and did not realize CNA #18 was involved with assisting another resident.	F 241			
F 244 SS=E	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION  When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility.  This REQUIREMENT is not met as evidenced by: Based on record review, review of Resident Council meeting minutes, and Grievance and Concern Forms, staff interview, and resident group interview, it was determined the facility failed to ensure call lights were answered in a timely manner for 10 of 14 residents present at a group meeting and one sampled resident (#7). This created the potential for more than minimal harm if staff did not respond promptly to an emergent situation or if residents' experienced falls when attempting to complete tasks without needed assistance. Findings include:  1. On July 26, 2016, a group meeting was conducted with 14 residents in attendance. Ten residents in the group meeting expressed concerns regarding the length of time it took staff to answer a call lights.  Resident Council Meeting minutes, dated 2/09/16, 4/12/16 and 6/21/16, documented that	F 244	F-244  Specific Residents Identified  Resident # 7 will be assessed by the Center Nurse Executive or designee on or before 8/31/16 for any adverse effect related to call light concerns. The 14 residents who attended the group meeting will be assessed by the Center Nurse Executive or designee on or before 8/31/16 for any adverse effect related to call light concerns. Any findings will be addressed and corrected by the Center Nurse Executive or designee on or before 8/31/16.  Identification of Other Residents  A review of call light response times	9/9/16	

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F 244	<p>Continued From page 17</p> <p>call lights not being answered remained an issue, especially on the evening shift.</p> <p>Grievance and Concern Forms for January 2016 through June 2016 documented a lack of timely response to call lights was an issue on the evening shift and weekends.</p> <p>On 7/28/16 at approximately 6:15 pm, the DON stated the facility was hoping to hire more staff and that weekend staff were hard to find. The present staff had been in-serviced and would again be in-serviced on answering call lights in a timely manner with respect for the residents.</p> <p>2. Resident #7 was admitted to the facility on 7/5/16 with diagnoses including history of knee replacement and chronic pain. Resident #7's admission MDS assessment, dated 7/15/16, documented she was cognitively intact, able to make all of her own decisions regarding care, and required extensive assistance from staff to complete her ADLs, including transferring from her bed to her wheelchair and back, bathing, dressing, and toileting.</p> <p>On 7/25/16 at approximately 10:30 a.m., Resident #7 stated that although most staff members were kind to her, she often had to wait between 30- and 60 minutes to have her call light answered when she needed assistance. Resident #7 stated, "They [staff] don't want me to, but if I have to wait too long on staff to help me I just get up and help myself."</p>	F 244	<p>during the evening and weekend shifts including tracking and trending will be completed by the Executive Director or designee on or before 8/31/16. Any findings will be addressed and changes implemented on or before 8/31/16 by the Center Nurse Executive or designee.</p> <p>A Resident Council meeting will be held by the Executive Director or designee on or before 8/31/16 related to call light response times. Any findings will be addressed and changes implemented on or before 8/31/16 by the Center Nurse Executive or designee.</p> <p>Systemic Changes</p> <p>Staffing patterns including break times and shift change will be reviewed by the Center Nurse Executive or designee on or before 8/31/16 to ensure that they are not happening at the time of greatest need by the residents. Any identified concerns will be addressed and corrected by the Center Nurse Executive or designee on or before 8/31/16. Facility staff will be educated by the Executive Director or designee on or before 8/31/16 regarding the importance of meeting residents' needs through timely response to call lights and staffing pattern changes.</p> <p>Monitoring</p> <p>Starting the week of 9/1/16, a call light response time audit of 5 call lights will be</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135104</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/28/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>TWIN FALLS CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>674 EASTLAND DRIVE TWIN FALLS, ID 83301</b>		
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F 244	Continued From page 18	F 244	completed during the evening shift and weekends by the Executive Director or designee weekly x 4 weeks and then monthly x 2 months to ensure that call lights are responded to timely and that residents' needs are met. The results of those audits will be reported to the Performance Improvement Committee for three months for review and follow up intervention. The Executive Director is responsible for compliance and monitoring. The Performance Improvement Committee will re- evaluate the need for further monitoring after 3 months. Results of the audits will also be reviewed in the resident council meeting monthly x 3 months.		
F 278 SS=D	<p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED</p> <p>The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p>	F 278	<p>Date of Compliance</p> <p>9/9/16</p>	9/9/16	

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F 278	<p>Continued From page 19</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview, it was determined the facility failed to ensure MDS assessments were coded accurately in the area of weight loss for 2 of 24 sampled residents (#1 and #2). This created the potential for a lack of care and services to address residents' weight loss due to inaccurate assessments. Findings include:</p> <p>1. Resident #2 was admitted to the facility on 2/15/13 with diagnoses that included Type II diabetes mellitus, dementia, cerebrovascular disease, dysphagia, hyperlipidemia, and hypertension.</p> <p>Resident #2's 4/26/16 MDS assessment documented she was 5-feet tall, weighed 109 lbs, required assistance with eating, was edentulous, and received a mechanically altered diet.</p> <p>Observations of Resident #2 during meals</p>	F 278	<p>F278</p> <p>Specific Residents Identified</p> <p>A modification of the MDS for Residents #1 and #2 that accurately reflects weight loss will be completed by the MDS Coordinator on or before 8/31/16.</p> <p>Identification of Other Residents</p> <p>The MDS <input type="checkbox"/> for residents who have had weight loss will be reviewed by the MDS Coordinator or designee on or before 8/31/16 to ensure that they were coded accurately. Any inaccurate findings will be corrected by the MDS Coordinator on or before 8/31/16.</p>		

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F 278	<p>Continued From page 20</p> <p>between 7/25/16 through 7/28/16 demonstrated she was dependent on staff for eating. Resident #2's intake during the survey varied from less than 25% (breakfast and lunch on 7/26/16) up to 100% (lunch on 7/27/16 and breakfast on 7/28/16).</p> <p>Resident #2's weight records for the previous 4 months were as follows:</p> <p>-3/13/16: 110.5 lbs -4/5/16: 119.5 lbs -4/11/16: 118 lbs -4/19/16: 111 lbs -4/25/16: 108.5 lbs -5/1/16: 105.5 lbs -5/15/16: 108 lbs -6/16/16: 96.5 lbs -6/21/16: 98 lbs -7/4/16: 97 lbs</p> <p>Resident #2's 4/26/16 Significant Change MDS documented she experienced a significant weight loss and was on a prescribed weight loss regimen. Resident #2 experienced a significant weight loss, however there was no evidence she was on a prescribed weight loss regimen. Resident #2's physician's orders did not include an order for diuretic medication in April 2016 or at any time after. There was no documentation in nurses' notes, nutrition progress notes, physicians' notes, or in Resident #2's care plan, that indicated Resident #2 was on a planned weight loss regimen. Resident #2's nutrition care plan, last updated on 3/22/15, documented she was at nutritional risk related to diagnoses of Type II diabetes, use of insulin, dementia, history of CVA, and wound care. The goal was for</p>	F 278	<p>Systemic Changes</p> <p>Facility Dietician and MDS Coordinator will be educated by the Center Nurse Executive or designee regarding accuracy of MDS assessment coding on or before 8/31/16. A post test will be administered to validate competency in coding on or before 8/31/16. The MDS Coordinator will review the MDS of residents with weight loss prior to submission for accuracy on or before 8/31/16.</p> <p>Monitoring</p> <p>Starting the week of 9/1/16, audits of 5 MDS <input type="checkbox"/> will be completed weekly x 4 weeks and then monthly x 2 months by the MDS Coordinator for accuracy regarding weight loss. The results of the audits will be reported to the Performance Improvement Committee for three months for review and follow up intervention. The Performance Improvement Committee will re-evaluate the need for further monitoring after 3 months. The Center Nurse Executive is responsible for compliance and follow up.</p> <p>Date of Compliance</p> <p>9/9/16</p>		

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F 278	<p>Continued From page 21 Resident #2 to eat at least 50%.</p> <p>The Dietitian and DON were interviewed together on 7/28/16 at 10:00 a.m. The Dietitian stated that on the MDS she assessed Resident #2 as being on a prescribed weight loss regimen because Resident #2 had edema in April 2016 and she expected her to lose weight. The DON verified Resident #2 was not prescribed a diuretic for weight loss, stating Resident #2 had medical conditions that contraindicated prescription of a diuretic medication.</p> <p>2. Resident #1 was admitted to the facility on 8/22/13 with diagnoses that included dementia, chronic kidney disease, Type II diabetes mellitus, and gastro-esophageal reflux disease. Resident #1's 5/17/16 Significant Change MDS assessment documented she was 5-foot and 1-inch tall and weighed 107 lbs. The MDS documented Resident #1 experienced a significant weight gain. However, Resident #1's weight records showed she experienced a significant weight loss instead.</p> <p>Resident #1's weight records documented the following:</p> <p>-1/5/16: 121 lbs -2/14/16: 122 lbs -3/13/16: 120.5 lbs -4/5/16: 116 lbs -5/1/16: 108 lbs</p> <p>On 7/28/16 at 10:00 am, the Dietician stated she erred on the MDS assessment. The Dietitian stated she should have assessed Resident #1 as having a significant weight loss, rather than a</p>	F 278			

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F 278	Continued From page 22 significant weight gain.	F 278			
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.  This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review, and staff interview, it was determined the facility failed to ensure necessary nursing care and services were provided to 3 of 24 sampled residents (#2, #16, & #18). The facility protocol to address hyperglycemia, following physician's orders for administering insulin and rechecking blood sugar, and notifying the physician of incidents of hyperglycemia were not followed, creating the potential for adverse health consequences. Findings include:  1. Resident #2 was admitted to the facility on 2/15/13 with diagnoses that included Type II diabetes mellitus. Resident #2's 4/26/16 MDS assessment documented she required assistance with eating, was edentulous, and on a mechanically altered diet. The MDS documented Resident #2 received insulin all 7 days in the assessment period.  Observations of Resident #2 on survey from 7/25/16 to 7/28/16 verified she was dependent on	F 309	F309  Specific Residents Identified Resident #2 was assessed by the Nurse Unit Manager on 8/19/16 for any adverse effects related to physician notification regarding blood sugars readings, insulin dose administration, rechecking blood sugars according to parameters, or incidents of incorrect insulin administration; no adverse effects noted. Resident #2 diabetic management and resident specific goals will be reviewed by the Center Nurse Executive or designee and the attending physician on or before 8/31/16, and order changes implemented and follow up completed as indicated at time of review.  Resident #16 was assessed by the Nurse Unit Manager on 8/19/16 for any adverse effects related to physician notification regarding blood sugars readings, insulin	9/9/16	

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F 309	<p>Continued From page 23</p> <p>staff for meals and had periods of sleepiness. She was observed at breakfast on 7/26/16 from 8:20 am to 9:00 am, did not initiate eating independently, and was fed by staff. Resident #2's head was slumped forward and her eyes were closed during the meal when she was not actively being fed by staff. Her tray card indicated she was on a consistent carbohydrate diet. Resident #2's intake was observed to vary between 25% (breakfast and lunch on 7/26/16) and 100% (lunch on 7/27/16 and breakfast on 7/28/16).</p> <p>On 7/28/16 at 9:23 am, the resident's physician stated Resident #2 had a recent period of medical instability corresponding with significant weight loss and a change in condition. Resident #2's meal intake and BG levels were both low and high with multiple changes being made to her insulin and diabetic regimen over the past 2 months. Resident #2's physician stated he was more concerned with low BGs than high BGs and reported Resident #2's hemoglobin A1C lab was recently 7; the goal was 7.5-8.</p> <p>Physician's Orders, dated 12/30/15, directed nursing staff to notify the physician for any two BG readings greater than 250 with an associated change in condition during all or part of two consecutive days, or two BG readings greater than 300 during all or part of 2 consecutive days, or any one BG reading greater than 400 as needed for diabetic management.</p> <p>Resident #2's BG levels were to be checked 3 times a day at 7:00 a.m., 12:00 p.m., and 5:00 p.m. with sliding scale parameters in place to address hypoglycemia (low blood sugar) and</p>	F 309	<p>dose administration, rechecking blood sugars according to parameters, or incidents of incorrect insulin administration; no adverse effects noted. Resident #16 diabetic management and resident specific goals will be reviewed by the Center Nurse Executive or designee and the attending physician on or before 8/31/16, and order changes implemented and follow up completed as indicated at time of review.</p> <p>Resident #18 was discharged from the facility on 8/6/16.</p> <p>Identification of Other Residents The Center Nurse Executive or designee will review insulin dependent residents on or before 8/31/16 for resident specific goals for diabetic control. The Center Nurse Executive or designee will follow up with the physician on or before 8/31/16 and implemented new orders for resident specific diabetic control and additional follow up as indicated.</p> <p>The Center Nurse Executive or designee will audit and identify residents during the last 30 days on or before 8/31/16 where physician orders or protocol was not followed for the following: addressing hyperglycemia, administration of insulin, rechecking blood sugars, or notifying physician of incidents of hyperglycemia. Identified residents will be assessed for adverse effects, reviewed for diabetic management and resident specific goals by the Center Nurse Executive/Designee</p>		

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F 309	<p>Continued From page 24 hyperglycemia (high blood sugar).</p> <p>Current insulin orders, dated 7/7/16, were: Humalog solution (insulin) 100 unit/ml 4 units with meals and Humalog solution 100 unit/ml per sliding scale of:</p> <p>0-150 = 0 units; 151-200 = 2 units; 201-250 =4 units; 251-300 = 6 units; 301-350 = 8 units; 351-400 = 10 units; if greater than 401, give 15 units and recheck BG in 2 hours.</p> <p>a. Failure to notify the physician of hyperglycemia</p> <p>SBAR Communication forms, Nurses' Notes, and Physician's Progress Notes documented Resident #2's physician was not notified of her high BG levels 4 times over the previous 5-week period:</p> <p>* 6/12/16: Resident #2's BG level at 12:00 pm was 311; BG level at 5:00 pm was 337. The physician was not notified of BG levels meeting the notification parameter of 2 BG readings greater than 300 within all or part of 2 consecutive days.</p> <p>* 6/22/16: Resident #2's BG level at 7:00 am was 345; BG level at 5:00 pm was 398. The physician was not notified of the BG levels meeting the notification parameter of 2 BG readings greater than 300 within all or part of 2 consecutive days.</p>	F 309	<p>and the attending physician on or before 8/31/16 with order changes implemented and follow up as indicated.</p> <p>Systemic Changes Beginning 8/31/16 newly admitted insulin dependent residents will be reviewed in a weekly CAR (Clinical At Risk) meeting by the CAR team to ensure that resident specific goals for diabetic control are reviewed and follow up for resident specific notification parameters are implemented as indicated.</p> <p>Beginning 9/9/16, prior to administration of sliding scale insulin, a second nurse will validate that the correct dose is being administered per the resident's individualized parameter.</p> <p>Licensed nurses will complete an insulin administration competency with post test administered by the Nurse Practice Educator or designee on or before 8/31/16.</p> <p>Beginning 9/9/16, nurses will update the 24 hour report for residents who have blood sugars outside of their physician ordered parameter or who require that insulin be held.</p> <p>Beginning 9/9/16, residents with parameters for insulin administration that include instructions for holding insulin will have those instructions printed in capital letters and highlighted in pink on the Medication Administration Record to alert</p>		

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F 309	<p>Continued From page 25</p> <p>* 7/1/16: Resident #2's BG level at 7:00 am was 315; BG level at 12:00 pm was 301; BG level at 5:00 pm was 313. The physician was not notified of BG levels meeting the notification parameter of 2 BG readings greater than 300 within all or part of 2 consecutive days.</p> <p>* 7/5/16: Resident #2's BG level was 349 at 12:00 pm; BG level at 5:00 pm was 346. The physician was not notified of BG levels meeting the notification parameter of 2 BG readings greater than 300 within all or part of 2 consecutive days.</p> <p>The DON was interviewed on 7/28/16 at 2:00 pm and stated she researched Resident #2's medical record and was unable to find verification of physician notification on 6/12/16, 6/22/16, 7/1/16 and 7/5/16.</p> <p>b. Incorrect sliding scale insulin</p> <p>Resident #2 was not administered the correct dose of sliding scale insulin on 5 occasions. She received less than the prescribed amount of insulin on 4 occasions and an excessive dose on one occasion.</p> <p>-6/17/16: Resident #2's BG level was 531 at 12:00 pm. According to the sliding scale parameters, she should have received 15 units of insulin, but received 10 units instead. Resident #2's subsequent BG level was 400, taken at 5:00 pm. There was no evidence her BG level was rechecked after 2 hours in accordance with the physician's order. A medication error report was not completed and there was no evidence the medication error was identified.</p>	F 309	<p>staff to the hold order.</p> <p>Licensed nurses will be educated on or before 8/31/16 by the Center Nurse Executive or designee regarding the facility hyperglycemia protocol, following physician orders for insulin administration and rechecking blood sugars, and notification for incidents of hyperglycemia according to resident specific parameters. Licensed nurses will completed a post-test to validate competency and understanding with additional follow up as indicated.</p> <p>Licensed nurses will be re educated on or before 9/9/16 by the Center Nurse Executive or designee on the diabetic management system, safe insulin administration and documentation.</p> <p>Monitoring</p> <p>Starting the week of 9/10/16, an audit of 5 insulin dependent residents will be completed by the Center Nurse Executive or designee daily x 3 weeks, weekly x 4 weeks and monthly x 2 months to ensure licensed nurses are addressing instances of hyperglycemia including: actions to address hyperglycemia, administering of insulin, rechecking blood sugar, and notifying physician of incidents of hyperglycemia. The results of those audits will be reported to the Performance Improvement Committee for three months</p>		

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F 309	<p>Continued From page 26</p> <p>-6/25/16: Resident #2's BG level was 441 at 7:00 am. According to the sliding scale parameters, she should have received 15 units of insulin, but received 10 units instead. Resident #2's subsequent BG level was 190, taken at 12:00 pm. There was no evidence Resident #2's BG level was rechecked after 2 hours in accordance with the physician's order, a medication error report was not completed, and there was no evidence the medication error was identified.</p> <p>-6/30/16: Resident #2's BG level was 441 at 5:00 pm. According to the sliding scale parameters, she should have received 15 units of insulin, but received 10 units instead. Resident #2's subsequent BG level was 315, taken at 5:00 am on 7/1/16. There was no evidence Resident #2's BG level was rechecked after 2 hours in accordance with the physician's order, a medication error report was not completed, and there was no evidence the medication error was identified.</p> <p>-7/9/16: Resident #2's BG level was 457 at 5:00 pm. According to the sliding scale parameters, she should have received 15 units of insulin, but received 10 units instead. Resident #2's subsequent BG level was 185, taken at 5:00 am on 7/10/16. There was no evidence Resident #2's BG level was rechecked after 2 hours in accordance with the physician's order, a medication error report was not completed, and there was no evidence the medication error was identified.</p> <p>-7/15/16: Resident #2's BG level was 482 at 5:00 pm. According to the sliding scale parameters,</p>	F 309	<p>for review and follow up intervention. The Center Nurse Executive is responsible for compliance and monitoring. The Performance Improvement Committee will re- evaluate the need for further monitoring after 4 months.</p> <p>Date of Compliance 9/9/16</p>		

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F 309	<p>Continued From page 27</p> <p>she should have received 15 units of insulin, but received 19 units instead. Resident #2's subsequent BG level was 204, taken at 7:00 am. on 7/16/16. There was no evidence Resident #2's BG level was rechecked after 2 hours in accordance with the physician's order, a medication error report was not completed, and there was no evidence the medication error was identified.</p> <p>On 7/28/16 at 2:00 pm, the DON stated she researched Resident #2's clinical record and was unable to find additional information documenting she received the correct sliding scale insulin doses or that a medication error report was completed on 6/17/16, 6/25/16, 6/30/16, 7/9/16 or 7/15/16.</p> <p>2. Resident #16 was admitted to the facility on 6/21/16 with diagnoses that included Type II diabetes.</p> <p>Resident #16's admission MDS assessment, dated 6/30/16, documented she received daily insulin injections during the assessment reference period.</p> <p>Resident #16's Diabetes Care Plan, dated 6/21/16, documented she was insulin dependent, staff was to monitor for signs and symptoms of hyper/hypoglycemia (high/low BG level) and report abnormal findings to the physician, and medication was to be administered as ordered.</p> <p>Resident #16's Physician Orders, dated 7/15/16, documented she was to have her BG checked four times daily (before meals and at bedtime) and was to receive Novolog Solution (insulin) 100</p>	F 309			

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

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FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135104</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/28/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>TWIN FALLS CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>674 EASTLAND DRIVE TWIN FALLS, ID 83301</b>		
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F 309	<p>Continued From page 28</p> <p>units per milliliter via sliding scale orders as follows:</p> <p>0 units for BG of 71-149 2 units for BG of 150-199 4 units for BG of 200-249 6 units for BG of 250-299 8 units for BG of 300-349 10 units for BG of 350-399</p> <p>Nursing was to notify the physician for BG less than 70; for BG greater than 250 with an associated change of condition during all or part of two consecutive days; or for two BG readings greater than 300 during all or part of two consecutive days; or any one reading above 400.</p> <p>Resident #16's MAR dated 7/16/16, documented the following BG readings above 300:</p> <ul style="list-style-type: none"> <li>* 7/1/16 at 11:00 am was 392</li> <li>* 7/2/16 at 11:00 am was 358, 4 pm was 407, and bedtime was 395</li> <li>* 7/3/16 at 11:00 am was 303, 4:00 pm was 350, and bedtime was 399</li> <li>* 7/4/16 at 4:00 pm was 320, and bedtime was 353</li> <li>* 7/5/16 at bedtime was 393</li> <li>* 7/6/16 at bedtime was 367</li> <li>* 7/7/16 at 4:00 pm was 302</li> <li>* 7/10/16 at 11:00 am was 304</li> <li>* 7/11/16 at bedtime was 323</li> <li>* 7/14/16 at bedtime was 344</li> <li>* 7/17/16 at 11:00 am was 351 and 4:00 pm was 330</li> <li>* 7/20/16 at 11:00 am was 378</li> <li>* 7/26/16 at bedtime was 300.</li> </ul>	F 309			

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F 309	<p>Continued From page 29</p> <p>Resident #16's Progress Notes and Change of Condition documentation was reviewed for 7/15/16. Documentation was found to indicate Resident #16's physician was notified of the 7/2/16 BG level of 407. Nothing further could be found in the documentation to indicate Resident #16's physician was notified of other BG readings greater than 300 during the month of July.</p> <p>On 7/27/17 at 3:45 p.m., LPN #18 stated the BG orders for all residents in the facility were complicated. She stated she would be looking over the previous day's BG readings (7/26/16) for residents in her care that day (7/27/16 ) because the orders were so complicated that she did not have time to review readings for the parameters each day. She stated, "The process is time consuming and confusing."</p> <p>On 7/28/16 at approximately 9:00 am, the DON stated there was a lack of documentation to verify Resident 16's physician was notified of high BG levels per physician's orders, although she felt Resident #16's physician was generally aware of her condition as he rounded in the facility 5 to 6 mornings per week.</p> <p>On 7/28/16 at 9:15 am, Resident #16's physician stated he was generally aware of Resident #16's high BG readings, and that he expected her readings to be high since she had been ill recently and was taking prednisone (an anti-inflammatory steroid). He stated that he felt he had most likely been notified of most of Resident #16's high BG readings, but that he did not have documentation to support that, and did not know specifically which readings he had/had not been notified of.</p>	F 309			

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F 309	<p>Continued From page 30</p> <p>3. Resident #18 was admitted to the facility on 3/15/16 with diagnosis of diabetes mellitus.</p> <p>Resident #18's Physician Orders, with a start date of 6/24/16, documented the resident was to receive Novolog Solution, 100 units/ml, before meals and at bedtime, inject per sliding scale:</p> <p>0 units for BG of 71-149 2 units for BG of 150-199 4 units for BG of 200-249 6 units for BG of 250-299 8 units for BG of 300-349 10 units for BG of 350-399</p> <p>Nursing staff was to notify the physician for BG less than 70; for BG greater than 250 with an associated change of condition during all or part of two consecutive days; or for two BG readings greater than 300 during all or part of two consecutive days; or any one reading above 400.</p> <p>Resident #18's MAR for July 2016 included the following BG levels greater than 300:</p> <p>7/17/16 at 9:00 pm the BG level was 330 7/18/16 at 5:00 pm the BG level was 338 7/21/16 at 5:00 pm the BG level was 364.</p> <p>There was no documentation in Resident #18's record that the physician was notified of the above BG readings over 300.</p> <p>On 7/8/16 at approximately 2:00 pm, the Medication Nurse stated the physician should have been notified per the orders written on the MAR.</p>	F 309			

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F 309	Continued From page 31  The facility's Blood Glucose Monitoring: Hyperglycemic Notifications policy, dated 1/1/16, read, "Physicians will be notified for any two blood glucose readings greater than 250 mg/dl with an associated change in condition during all or part of two consecutive days. Or Two readings greater than 300 mg/dl during all or part of two consecutive days. Or Any one reading greater than 400 mg/dl. For hypoglycemia the physician will be immediately notified for any blood glucose level less than 70 mg/dl." This policy was not followed.	F 309			
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS  A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section.  This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility failed to ensure 1 of 9 (#9) sampled residents was assessed for the use of a special eating utensil prior to implementation and determine how the utensil would improve or maintain his ability to eat independently. This failed practice created the potential for decreased independence when Resident #9 could not maintain his grip/grasp on the enlarged utensil handle. Findings included:  Resident #9 was admitted to the facility with multiple diagnoses including history of CVA, flaccid hemiplegia affecting right dominant side, and muscle weakness.	F 311	F311 Specific Residents Identified Resident #9 was assessed by the Nurse Unit Manager on 8/18/16 for any adverse effects related to using a special eating utensil; no adverse effects noted. The physician was notified of concern for use of specialized eating utensil; order changes implemented for therapy evaluation of continued use of adaptive dining equipment.  Identification of Other Residents A review of residents utilizing adaptive dining equipment will be completed by the	9/9/16	

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F 311	<p>Continued From page 32</p> <p>Resident #9's Quarterly MDS assessment, dated 6/8/16, documented he was understood by others, usually understood others, and required total dependence of one staff for eating.</p> <p>Resident #9's current Physician Orders, dated July 2016, did not include an order for an adaptive eating utensil.</p> <p>Resident #9's current Nutrition Care Plan documented that due to weakness and limited mobility post CVA, he required assistance and cueing with meals; frequently chose to eat with his hands and not use eating utensils; and used a lipped plate and built up utensils with meals to improve his dining experience and quality of life at meal time.</p> <p>On 7/26/16 at 8:30 am, Resident #9 was provided with a black handled spoon with his breakfast. LN #15 assisted Resident #9 with placement of the spoon in his left hand and encouraged him to use the spoon to eat his oatmeal. Resident #9 attempted several times to scoop the hot cereal on to his spoon, but was unsuccessful as he repeatedly lost his grip/grasp on the spoon handle. He put the spoon down after several unsuccessful attempts and began eating the cereal with his hands. LN #15 redirected Resident #9 not to use his hands and to use the spoon. Resident #9 stated, "You feed me." Throughout the meal Resident #9 was observed holding a 240 cc cup in his left hand, which he drank from without difficulty.</p> <p>On 7/26/16 at 6:41 pm, Resident #9 was provided with a black handled spoon with his</p>	F 311	<p>Center Nurse Executive or designee with Director of Rehab or designee on or before 8/31/16. Residents were screened by therapy personnel for need of continued use or discontinuation of adaptive equipment. Resident physician orders and care plans will be updated as indicated.</p> <p><b>Systemic Changes</b> Facility staff will be educated by the Center Nurse Executive or designee on or before 8/31/16 regarding utilization of adaptive dining equipment including use of written communication for initiation or discontinuation of dining adaptive equipment. Beginning 8/31/16 the facility will utilize its current <input type="checkbox"/> Quality of Life Rounds <input type="checkbox"/> to monitor ongoing use or potential need of dining adaptive equipment by completing one round quarterly during a meal; residents identified during the round for potential discontinuation, reevaluation, or new need for adaptive dining equipment will have follow up completed as indicated.</p> <p><b>Monitoring</b> Starting the week of 9/1/16, an adaptive dining equipment audit of 5 residents will be completed by the Center Nurse Executive or designee weekly x 4 weeks and then monthly x 2 months to ensure resident <input type="checkbox"/>s utilizing adaptive dining equipment have been assessed for use, have physician orders, and care plan in place for adaptive dining equipment. The results of those audits will be reported to</p>		

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F 311	<p>Continued From page 33</p> <p>dinner and the plate was placed directly in front of him on the table. CNA #13 moved Resident #9's plate up and to the right of him and fed Resident #9 his dinner. CNA #13 was not observed encouraging Resident #9 to do what he could for himself and/or to use the spoon. Throughout the meal Resident #9 was observed holding a 240 cc cup in his left hand from which he drank without difficulty.</p> <p>On 7/26/16 at 7:15 pm, when asked why she moved Resident #9's plate away from him, CNA #13 stated, "If we place his plate directly in front of him he will start reaching for items on the plate with his fingers. He won't even attempt to use the silverware." When asked if she encouraged Resident #9 to do as much as he could for himself, she stated, "We decided it was more hygienic for staff to feed [Resident #9]." CNA #13 stated Resident #9 loses his grip on the handles of the utensil. When asked if she had reported that to the nurse, CNA #13 stated she had not "because the nurses were already aware."</p> <p>On 7/28/16 at 4:52 pm, a COTA was interviewed and stated it was the first time she had heard of Resident #9 using an adaptive utensil with meals. The COTA stated Occupational Therapy (OT) had not been asked to screen Resident #9 regarding his decreased independence with meals. She stated OT should have received a request from nursing to screen Resident #9 to determine if he needed an assessment for OT services, including the use of adaptive equipment.</p>	F 311	<p>the Performance Improvement Committee for three months for review and follow up intervention. The Center Nurse Executive is responsible for compliance and monitoring. The Performance Improvement Committee will re- evaluate the need for further monitoring after 3 months.</p> <p>Date of Compliance 9/9/16</p>		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS	F 312		9/9/16	

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F 312	<p>Continued From page 34</p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure 1 of 24 sampled residents (#14) received assistance with ADLs, including bathing/showers as directed by her plan of care. This deficient practice placed Resident #14 at risk of physical or psychosocial harm to due a lack of basic hygienic practices. Findings include:</p> <p>Resident #14 was admitted to the facility on 8/11/15 with diagnoses including right femur fracture and history of falls.</p> <p>Resident #14's annual MDS assessment, dated 8/18/15, documented she required extensive assistance from staff to complete all ADLs, including bathing.</p> <p>Resident #14's ADL Care Plan, dated 9/1/15, documented she required extensive assistance from one staff to complete ADL care, including bathing.</p> <p>Resident #14's Physician Orders, dated 9/2015, documented Resident #14 was to be offered a bath or shower twice weekly.</p> <p>Resident #14's ADL Records documented she did not receive a shower or bath from 9/5/15 to</p>	F 312	<p>F-312</p> <p>Specific Residents Identified</p> <p>Resident #14 has been discharged from the facility.</p> <p>Identification of Other Residents</p> <p>An audit of the resident ADL records will be conducted by the Center Nurse Executive or designee on or before 8/31/16 to ensure that showers/baths are provided and scheduled and documented. Any findings will be addressed and corrected including offering make up baths/showers by the Center Nurse Executive or designee on or before 8/31/16</p> <p>Systemic Changes</p> <p>Nursing staff will be been educated on or before 8/31/16 by the Center Nurse Executive or designee regarding the provision of showers/baths to residents as scheduled as well as the documentation requirements and alternatives when a</p>		

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F 312	Continued From page 35 9/30/15 (25 days). The ADL Record documented Resident #14 refused a bath on 9/26/15. No other refusals were documented during the month.  Resident #14's Progress Notes for 9/2015 did not include documentation that Resident #14 had a bath or shower, or refused attempts to provide a bath or shower, between 9/5/15 and 9/30/15.  On 7/28/16 at approximately 3:15 p.m., the DON stated there was no documentation to verify Resident #14 was bathed or showered between 9/5/15 and 9/30/15. She also stated Resident #14 refused a bath on 9/26/16, but thee was no documentation of other refusals.	F 312	resident refuses. A communication board was implemented for nursing assistants to communicate refusals of baths/showers on or before 8/31/16 to track completion of bath/shower refusals. Nurse managers to monitor communication board daily for completion of showers/baths.  Monitoring  Starting the week of 9/1/16, an audit will be completed by the Center Nurse Executive or designee weekly x 4 weeks and then monthly x 2 months to ensure that showers/baths are completed as scheduled and documented. Audits will be reviewed at the Performance Improvement Committee meeting monthly for 3 months for review and follow up intervention. The Performance Improvement Committee will re evaluate the need for further monitoring after 3 months. The Center Nurse Executive is responsible for monitoring and compliance.  Date of Compliance  9/9/16		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS  The facility must ensure that residents are free of	F 333		9/9/16	

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F 333	<p>Continued From page 36 any significant medication errors.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure administration of insulin at the dosage identified in her physician's orders. This was true for 1 of 24 sampled residents (Resident #2). This result in a significant medication error which placed Resident #2 at risk of blood sugar (BG) levels that were too high or too low. Findings include:</p> <p>Resident #2 was admitted to the facility on 2/15/13 with diagnosis of Type II diabetes mellitus. Resident #2's 4/26/16 MDS assessment documented she required assistance with eating, was edentulous, and on a mechanically altered diet. The MDS documented Resident #2 received insulin all 7 days in the assessment period.</p> <p>Resident #2's physician was interviewed on 7/28/16 at 9:23 am. The physician stated Resident #2 had a recent period of medical instability corresponding with significant weight loss and a change in condition. Resident #2's meal intake and BG levels were both low and high with multiple changes being made to her insulin and diabetic regimen over the past 2 months. Resident #2's physician stated he was more concerned with low BGs than high BGs and reported Resident #2's hemoglobin A1C lab was recently 7; the goal was 7.5-8.</p> <p>Resident #2's Current insulin orders, dated 7/7/16, were: Humalog solution (insulin) 100</p>	F 333	<p>F333</p> <p>Specific Residents Identified Resident #2 was assessed by the Nurse Unit Manager on 7/28/16 for any adverse effects related to incorrect insulin administration; no adverse effects noted. A Medication Error Incident Report was completed by the Nurse Unit Manager on 7/28/16 identifying the incorrect dose errors.</p> <p>Identification of Other Residents The Center Nurse Executive or designee will review medication administration records for last 30 days for insulin dependent residents on or before 8/31/16. Residents identified as having received incorrect insulin dosing will be assessed, incident reports, and follow up as indicated will be completed at the time of the review.</p> <p>Systemic Changes Beginning 9/9/16, prior to administration of sliding scale insulin, a second nurse will validate that the correct dose is being administered per the resident's individualized parameter.</p> <p>Beginning 9/9/16, nurses will update the 24 hour report for the residents who have blood sugars outside of their physician</p>		

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F 333	<p>Continued From page 37</p> <p>unit/ml 4 units with meals and Humalog solution 100 unit/ml per sliding scale of:</p> <p>0-150 = 0 units; 151-200 = 2 units; 201-250 = 4 units; 251-300 = 6 units; 301-350 = 8 units; 351-400 = 10 units; if greater than 401, give 15 units and recheck BG in 2 hours.</p> <p>Resident #2 was not administered the correct dose of sliding scale insulin on 5 occasions. She received less than the prescribed amount of insulin on 4 occasions and too much on one occasion. These failures created the potential for Resident #2's BG level to remain high (when less insulin was administered than ordered) or to decrease too rapidly (when more insulin was administered than ordered).</p> <p>-6/17/16: Resident #2's BG level was 531 at 12:00 pm. According to the sliding scale parameters, she should have received 15 units of insulin; she received 10 units instead. Resident #2's subsequent BG level was 400, taken at 5:00 pm. There was no evidence her BG level was rechecked after 2 hours, in accordance with the physician's order. A medication error report was not completed; there was no evidence the medication error was identified.</p> <p>-6/25/16: Resident #2's BG level was 441 at 7:00 am. According to the sliding scale parameters, she should have received 15 units of insulin; she received 10 units instead. Resident #2's subsequent BG level was 190, taken at 12:00</p>	F 333	<p>ordered parameter or who require that insulin be held.</p> <p>Beginning 9/9/16, resident's with parameters for insulin administration that include orders for holding insulin will have those instructions printed in capital letters and highlighted in pink on the Medication Administration Record to alert staff to the hold order.</p> <p>Licensed nurses have been educated by the Center Nurse Executive or designee on or before 8/31/16 regarding medication administration specifically insulin dosing. Licensed nurses were evaluated for competency of medication administration of insulin with corrective actions as needed on or before 8/31/16.</p> <p>Licensed nurses will be re educated on or before 9/9/16 by the Center Nurse executive or designee regarding the diabetic management system and safe insulin administration and documentation.</p> <p>Monitoring Starting the week of 9/10/16, an audit of 5 residents will be completed by the Center Nurse Executive or designee daily x 3 weeks, weekly x 4 weeks and then monthly x 2 months to ensure residents are receiving insulin dosing as per physician orders. The results of those audits will be reported to the Performance Improvement Committee for three months for review and follow up intervention. The</p>		

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F 333	<p>Continued From page 38</p> <p>pm. There was no evidence Resident #2's BG level was rechecked after 2 hours in accordance with the physician's order. A medication error report was not completed; there was no evidence the medication error was identified.</p> <p>-6/30/16: Resident #2's BG level was 441 at 5:00 pm. According to the sliding scale parameters, she should have received 15 units of insulin; she received 10 units instead. Resident #2's subsequent BG level was 315, taken at 5:00 am. on 7/1/16. There was no evidence Resident #2's BG level was rechecked after 2 hours in accordance with the physician's order. A medication error report was not completed; there was no evidence the medication error was identified.</p> <p>-7/9/16: Resident #2's BG level was 457 at 5:00 pm. According to the sliding scale parameters, she should have received 15 units of insulin; she received 10 units instead. Resident #2's subsequent BG level was 185, taken at 5:00 am on 7/10/16. There was no evidence Resident #2's BG level was rechecked after 2 hours in accordance with the physician's order. A medication error report was not completed; there was no evidence the medication error was identified.</p> <p>-7/15/16: Resident #2's BG level was 482 at 5:00 pm. According to the sliding scale parameters, she should have received 15 units of insulin; she received 19 units instead. Resident #2's subsequent BG level was 204, taken at 7:00 am on 7/16/16. There was no evidence Resident #2's BG level was rechecked after 2 hours in accordance with the physician's order. A</p>	F 333	<p>Center Nurse Executive is responsible for compliance and monitoring. The Performance Improvement Committee will re- evaluate the need for further monitoring after 4 months.</p> <p>Date of Compliance 9/9/16</p>		

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F 333	Continued From page 39 medication error report was not completed; there was no evidence the medication error was identified.  The DON was interviewed on 7/28/16 at 2:00 pm and stated she researched Resident #2's medical record and was unable to find additional information to show she received the correct sliding scale insulin doses or that a medication error report was completed on 6/17/16, 6/25/16, 6/30/16, 7/9/16 or 7/15/16. The DON stated a telephone order should be found for administration of insulin outside of regular or sliding scale administration. The DON stated the unit nurses reviewed the medication administration records; however no formal auditing for insulin administration had recently been, or was currently, in place.	F 333			
F 363 SS=E	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED  Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed.  This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident family member interview, and staff interview, it was determined the facility failed to ensure menus met the nutritional needs of residents. This was true for 10 of 14 residents in the resident group meeting and 1 of 24 sampled residents (#14) who expressed concerns	F 363	F-363  Specific Residents Identified  Resident #14 was discharged from the facility. The 14 residents who attended the group meeting will be assessed by the	9/9/16	

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F 363	<p>Continued From page 40 regarding the menus. This deficient practice created the potential for residents to experience weight loss and/or loss of self-worth due to the inability to control the foods served at meals. Findings include:</p> <p>The resident group interview was held on 7/26/16 at 1:30 p.m. with 14 residents, 10 of whom expressed concerns with the menu. Residents stated they were served the same foods repeatedly and there was a lack of variety. Three residents stated they were too often served potatoes. One resident stated the menu was "made back east,"s/he did not know what was being served, and the dishes were not foods s/he was accustomed to eating.</p> <p>Resident #14's family member stated in an interview on 10/2/15 that he/she was concerned Resident #14 received the same foods. The family member stated zucchini was served 3 times a week.</p> <p>The Dietary Manager was interviewed on 7/25/16 at 9:35 am and on 7/28/16 at 9:15 am. She stated the regular diet had an alternate entrée, vegetable and starch on the menu for lunch and dinner every day. The Dietary Manager stated the facility used a 3-week spring/summer cycle menu developed by a corporate dietitian located on the east coast. The Dietary Manager stated neither she nor the residents had direct input into the development or revision of the cycle menu. She stated residents planned a "meal of the month" and that was how residents were provided with input. The Dietary Manager stated chicken was a frequent item on the menu.</p>	F 363	<p>Center Nurse Executive or designee on or before 8/31/16 for any adverse effect related to menu concerns. Any findings will be addressed and corrected by the Center Nurse executive or designee on or before 8/31/16.</p> <p>Identification of Other Residents</p> <p>A review of the facility menus served will be completed by the Executive Director with the Resident Council on or before 8/31/16 to determine possible changes to the menus. Alternate choices will be added to the daily menu so that there are two different vegetables available at the lunch meal and a potato with an additional starch such as rice or noodles will be available at the lunch meal. A meat will be added to the always available menu to increase the variety available to residents. This change will be made on or before 8/31/16 by the Director of Dining Services and the Registered Dietician.</p> <p>Systemic Changes</p> <p>A resident council meeting will be held by the Director of Dining Services on or before 8/31/16 to review resident choices for new available alternates for vegetables and potatoes and the always available menu changes for meats. Beginning on or before 8/31/16, an "always available" menu will be implemented by the Center Director of Dining Services that includes additional</p>		

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F 363	<p>Continued From page 41</p> <p>The Dietitian was interviewed on 7/28/16 at 11:30 am and stated she did not have input into the menu and had not reviewed or signed off on any menu changes. The Dietitian verified the menu was developed by a corporate dietitian.</p> <p>Review of the menu and observations noted concerns with menu repetition:</p> <p>* Potatoes were on the menu, as either the main selection or as the alternate, a total of 42 times in 3 weeks, or an average of 14 times per week.</p> <p>* Chicken was on the menu, as either the main selection or as the alternate, a total of 20 times in 3 weeks, or an average of 6.7 times per week.</p> <p>Review of the menu identified concerns with the lack of vegetable exchanges at the noon meal. There were 6 instances in which there was no vegetable exchange for the noon meal as follows:</p> <p>a. Week A</p> <p>-Lunch on Monday consisted of a ham and Swiss cheese sandwich on rye bread with a lettuce and tomato garnish and deviled egg potato salad. The alternate on this date was breaded chicken strips with tater tots and wheat bread. This meal was observed served on 7/25/16 at 12:20 pm. The sandwich was served with potato salad, one piece of lettuce and one thin tomato slice; this did not constitute a full vegetable exchange (1 cup raw vegetable according to the Academy of Nutrition and Dietetics). The alternate of breaded chicken strips was served with tater tots and bread; neither the lettuce, tomato slice nor any</p>	F 363	<p>meat options. Alternate choices will be added to the daily menu on or before 8/31/16 so that there are two different vegetables available at the lunch meal and a potato with an additional starch such as rice or noodles available at the lunch meal. This menu will be reviewed by the Registered Dietician prior to implementation to ensure that resident nutritional needs are met. The "always available" menu and the daily menu changes will be reviewed by the Director of Dining Services at the monthly resident council meeting starting with the September meeting to ensure that residents are satisfied with the available options. The residents attending the resident council meeting held on or before 8/31/16 will be educated that off menu requests will be honored as available. Facility staff will be educated on the "always available" menu and daily alternate changes by the Executive Director or designee on or before 8/31/16.</p> <p>Monitoring</p> <p>Starting the week of 9/1/16, audits will be completed by the Executive Director or designee of 3 meals per week x 4 weeks and weekly x 2 months to ensure that the menus meet the nutritional needs of the residents. Menus will be reviewed monthly x 3 months with the resident council by the Executive Director or designee to ensure that residents are aware of the menu changes and</p>		

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F 363	<p>Continued From page 42</p> <p>other vegetable were observed to be served to residents who selected the alternate.</p> <p>-Lunch on Tuesday consisted of chicken and tarragon soup, beef and macaroni casserole and wheat bread. The alternate on this date consisted of cottage cheese fruit platter, and zucchini bread. The end of the meal was observed at 1:02 pm on 7/26/16; no vegetable was served with either the regular or alternate selection.</p> <p>-Lunch on Friday consisted of a hamburger on a roll, lettuce and tomato garnish, pickle, and French fries. A garnish of lettuce and a tomato slice did not constitute a full vegetable exchange, equal to 1 cup raw vegetable. The alternate consisted of a fried egg sandwich with French fries; neither the lettuce, tomato slice nor any other vegetable were listed on the menu under the alternate selection.</p> <p>b. Week B</p> <p>-Lunch on Tuesday consisted of a fish fillet on a roll, lettuce and tomato garnish, and parmesan tater tots. A garnish of lettuce and a tomato slice did not constitute a full vegetable exchange, equal to 1 cup raw vegetable.</p> <p>c. Week C</p> <p>-Lunch on Wednesday consisted of an Italian submarine sandwich with potato salad and pickle garnish. The alternate consisted of a hot turkey sandwich with poultry gravy and mashed potatoes. A vegetable was missing with both the regular and alternate selections.</p>	F 363	<p>alternates that are available. Results of the audits will be reported to the Performance Improvement Committee for three months for review and follow up intervention. The Performance Improvement Committee will re-evaluate the need for further monitoring after 3 months. The Executive Director is responsible for compliance and monitoring.</p> <p>Date of Compliance 9/9/16</p>		

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F 363	<p>Continued From page 43</p> <p>-Lunch on Saturday consisted of a hot dog on a bun with pickle relish and baked beans. The alternate consisted of a pepper steak sandwich with pickle garnish and baked beans. A vegetable was missing with both the regular and alternate selections.</p> <p>Review of the menu and observations identified the alternate starch or vegetable was identical to the main starch or vegetable as follows:</p> <p>a. Week A</p> <p>-Lunch on Sunday included seasoned peas listed as the vegetable for the main and alternate selections.</p> <p>-Dinner on Sunday included hash browns listed as the starch for the main and alternate selections.</p> <p>-Dinner on Monday included roasted potato medley as the starch for the main and alternate selections.</p> <p>-Dinner on Tuesday included fresh mashed potatoes as the starch for the main and alternate selections.</p> <p>-Dinner on Wednesday included oven roasted potatoes as the starch for the main and alternate selections.</p> <p>-Dinner on Thursday included broccoli florets as the vegetable for the main and alternate selections.</p> <p>-Lunch on Friday included French fries as the</p>	F 363			

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F 363	Continued From page 44 starch for the main and alternate selections.  -Dinner on Friday included O'Brien potatoes as the starch for the main and alternate selections.  -Lunch on Saturday included creamy coleslaw as the vegetable for the main and alternate selections.  b. Week B  -Lunch on Sunday included green beans and onions as the vegetable for the main and alternate selections.  -Lunch on Monday included parmesan Tater Tots as the starch for the main and alternate selections.  -Dinner on Monday included red bliss potatoes as the starch for the main and alternate selections.  -Dinner on Tuesday included Lyonnaise potatoes as the starch for the main and alternate selections.  -Dinner on Wednesday included hash brown casserole as the starch for the main and alternate selections.  -Dinner on Thursday included garlic mashed potatoes as the starch for the main and alternate selections.  -Dinner on Friday included seasoned green beans as the vegetable for the main and alternate selections.	F 363			

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F 363	Continued From page 45  -Dinner on Saturday included seasoned California blend vegetables as the vegetable for the main and alternate selections.  c. Week C  -Lunch on Sunday included baked potatoes as the starch for the main and alternate selections.  -Lunch on Monday included fiesta corn as the vegetable for the main and alternate selections.  -Dinner on Tuesday included creamed potatoes as the starch for the main and alternate selections.  -Dinner on Thursday included garlic seasoned potatoes as the starch for the main and alternate selections.  -Dinner on Friday included broccoli florets as the vegetable for the main and alternate selections.  -Lunch on Saturday included baked beans as the starch for the main and alternate selections.  -Dinner on Saturday included rosemary potatoes as the starch for the main and alternate selections.	F 363			
F 461 SS=D	483.70(d)(1)(vi)-(vii), (d)(2) BEDROOMS - WINDOW/FLOOR, BED/FURNITURE/CLOSET  Bedrooms must have at least one window to the outside; and have a floor at or above grade level.  The facility must provide each resident with-- (i) A separate bed of proper size and height for	F 461		9/9/16	

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F 461	<p>Continued From page 46</p> <p>the convenience of the resident;</p> <p>(ii) A clean, comfortable mattress;</p> <p>(iii) Bedding, appropriate to the weather and climate; and</p> <p>(iv) Functional furniture appropriate to the resident ' s needs, and individual closet space in the resident ' s bedroom with clothes racks and shelves accessible to the resident.</p> <p>CMS, or in the case of a nursing facility the survey agency, may permit variations in requirements specified in paragraphs (d)(1)(i) and (ii) of this section relating to rooms in individual cases when the facility demonstrates in writing that the variations--</p> <p>(i) Are in accordance with the special needs of the residents; and</p> <p>(ii) Will not adversely affect residents' health and safety.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and resident interview, it was determined the facility failed to ensure necessary furniture was provided for a resident's needs. This was true for 1 of 9 (#5) residents sampled for homelike environment in the facility. This deficient practice had the potential to negatively affect Resident #3's sense of control over his environment and the ability of Resident #3 or his family and friends to sit in a chair in his room. Findings included:</p> <p>Resident #5 was admitted to the facility with multiple diagnoses, including femur fracture,</p>	F 461	<p>F461</p> <p>Specific Residents Identified</p> <p>A chair will be placed in the room of resident# 5 by the Executive Director on or before 8/31/16.</p> <p>Identification of Other Residents</p>		

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F 461	<p>Continued From page 47</p> <p>COPD, and adjustment disorder with depressed mood.</p> <p>During observations throughout the survey of Resident #5's room from 7/25/16 to 7/28/16, a chair was not available for the resident and/or visitors to sit in.</p> <p>On 7/28/16 at 4:40 pm, when asked where he sits or his friends and family sit when they visit, Resident #5 stated, "I don't and they don't because I don't have a [expletive] chair to sit in!" When asked if he would like to have a chair in his room, he stated, "Yes, I would like to have a chair in room."</p>	F 461	<p>An audit of resident rooms will be completed on or before 8/31/16 by the Executive Director and to ensure that there is a chair available in each patient room for the resident or visitors to use.</p> <p><b>Systemic Changes</b></p> <p>Facility staff will be educated by the Executive Director or designee on or before 8/31/16 regarding provision of a chair for each patient or their visitor to use. Staff educated to notify the Executive Director for correction if there is not a chair for each resident or visitor in each room. Residents will be reminded by the Executive Director in Resident Council on or before 8/31/16 that if they would like additional chairs for visitors, they should request a chair from the licensed nurse or they can be shown to an area in the facility to visit where there is extra room for visiting in the dining room, sitting room or conference room. Residents who choose to not have a chair in their room for visitors will have this noted in their care plan.</p> <p><b>Monitoring</b></p> <p>Starting the week of 9/1/16, an audit will be completed by the Executive Director or designee weekly x 4 weeks and then monthly x 2 months to ensure that there is a chair for each patient or their visitor in their room who would like one. A report will be submitted to the Performance</p>		

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F 461	Continued From page 48	F 461	Improvement Committee for 3 months for review and follow up intervention. The Performance Improvement Committee will re-evaluate the need for further audits after 3 months. The Executive Director is responsible for monitoring and compliance.		
F 507 SS=D	<p>483.75(j)(2)(iv) LAB REPORTS IN RECORD - LAB NAME/ADDRESS</p> <p>The facility must file in the resident's clinical record laboratory reports that are dated and contain the name and address of the testing laboratory.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure laboratory test results were included in residents' records. This was true for 1 of 24 sampled residents (#6) and placed residents at risk of harm if physicians and other staff did not have the results of laboratory tests upon which to base care and treatment decisions. Findings include:</p> <p>Resident #6 was admitted to the facility on 6/2016 with diagnoses including kidney failure, Type II diabetes, Stage II pressure ulcer, and severe protein-calorie malnutrition.</p>	F 507	<p>Date of Compliance 9/9/16</p> <p>F507</p> <p>Resident #6 was discharged from the facility on 7/30/16.</p> <p>Identification of Other Residents A review of residents with orders for laboratory testing in the last 30 days will be completed by the Center Nurse Executive or designee on or before 8/31/16. Residents identified as not having lab results available in the chart will be assessed for adverse effects. The lab results of identified residents will be</p>	9/9/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135104</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/28/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>TWIN FALLS CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>674 EASTLAND DRIVE TWIN FALLS, ID 83301</b>		
(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 507	<p>Continued From page 49</p> <p>Resident #6's admission MDS assessment, dated 7/5/16, documented she was cognitively intact and able to make all of her own decisions regarding care.</p> <p>Resident #6's Physician Orders, dated 6/30/16, documented the following laboratory tests were to be drawn for her on 6/30/16: CBC (complete blood count), CMP (comprehensive metabolic panel), Mag (magnesium level), Vitamin B12 level, Vitamin D level, and A1C (hemoglobin A1C, a test for long term blood sugar levels) for diagnoses of Type II diabetes, Stage II pressure ulcer and chronic kidney disease.</p> <p>Resident #6's clinical record did not include documentation of results of the ordered laboratory tests.</p> <p>On 7/26/16 at approximately 3:45 pm, the DON stated Resident #6's ordered laboratory results were not in her clinical record. She provided a copy of the laboratory reports drawn on 6/30/16 and stated the report had been faxed to the facility by the lab on 7/26/16 after she was unable to find the report in Resident #6's clinical record.</p>	F 507	<p>obtained from lab facility on or before 8/31/16 and placed in medical record for review by the physician.</p> <p><b>Systemic Changes</b> Beginning 8/31/16, a place card will be placed into the lab section of the record until lab records are received. Beginning 8/31/16, lab logs will be reviewed during the clinical morning meeting to ensure lab results are received, reviewed, and filed timely. Licensed nurses will be educated by the Center Nurse Executive or designee on or before 8/31/16 regarding lab result availability including the implementation of lab result place cards and utilizing the lab log.</p> <p><b>Monitoring</b> Starting the week of 9/1/16, a lab result audit of 5 residents will be completed by the Center Nurse Executive or designee weekly x 4 weeks and then monthly x 2 months to ensure resident's laboratory results are available in the medical record. The results of those audits will be reported to the Performance Improvement Committee for three months for review and follow up intervention. The Center Nurse Executive is responsible for compliance and monitoring. The Performance Improvement Committee will re-evaluate the need for further monitoring after 3 months.</p> <p><b>Date of Compliance</b> 9/9/16</p>		



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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RICHARD M. ARMSTRONG – Director

TAMARA PRISOCK—ADMINISTRATOR  
LICENSING & CERTIFICATION  
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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](mailto:fsb@dhw.idaho.gov)

August 26, 2016

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

Provider #: 135104

Dear Ms. Bentzler:

On **July 28, 2016**, an unannounced on-site complaint survey was conducted at Twin Falls Center. The complaint was investigated in conjunction with the recertification survey conducted between July 15, 2016 and July 18, 2016. Five surveyors were onsite during the survey. The closed medical record of Resident 14 was reviewed; observations were made; staff members and current residents were interviewed.

The complaint allegations were in regards to issues that occurred prior to the resident's discharge from the facility in January 2015. The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00007166**

**ALLEGATION #1:**

The facility lacked sufficient staff and call light response times were slow.

**FINDINGS:**

There was a lack of evidence to substantiate the allegation of understaffing during the alleged time frame of September of 2015, however, the concern was substantiated based on group interview and for three other residents living in the facility at the time of the investigation. F tag 157 (grievance of group) was cited related to group and individual resident complaints regarding call light wait times being too long.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #2:

The facility does not have Registered Nurses (RNs) on staff, and the Licensed Practical Nurses (LPNs) do not answer call lights.

FINDINGS:

Nursing schedules and daily staffing reports were reviewed for the months of September, October, and November 2015 and June and July 2016. Sufficient RN staff was noted on all schedules. Residents and staff were interviewed about nursing staffing and no concerns were identified.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The facility stopped repositioning an identified resident, and the resident developed pressure sores.

FINDINGS:

The identified resident's record was reviewed and indicated the resident had pressure areas when she was admitted to the facility. Although the resident did develop open areas during her stay at the facility, the resident's family members were educated multiple times about risk related to not repositioning the resident in bed in addition to the risk related to requesting the resident be placed on a regular (non-low-air-loss) mattress. The facility went so far as to allow one family member to lay on different types of mattresses to help determine what would be most beneficial to the resident for comfort and pressure relief. According to the resident's clinical record, appropriate care was provided and the resident's skin was completely healed at the time of her discharge to an assisted living facility in January of 2016.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

An identified resident was placed on an air mattress at the time of admission that would not hold air. When the resident's family expressed concern about this development, the facility discontinued the mattress although the resident's clinical condition warranted continued use.

FINDINGS:

The identified resident's medical record was reviewed and staff were interviewed. The identified resident was placed on a low-air-loss mattress at the time of admission to the facility due to the fragile nature of her skin and suspected deep tissue injuries. Family members requested the resident be placed on a regular mattress because they felt the air mattress was not as comfortable as a regular mattress would be. Staff educated the family regarding the low-air-loss mattress and how it operated (the resident should sink into the middle). The family chose to remove the low-air-loss mattress and place a regular mattress on the resident ' s bed. This wish was respected and education was documented regarding the possible negative effects.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #5:

The facility did not clearly communicate with family regarding an identified resident's clinical condition and treatment goals.

FINDINGS:

The identified resident's clinical record was reviewed and interviews were conducted with the facility Business Office Manager and clinical staff. The identified resident was admitted to the facility under her Medicare benefit and her medical status improved significantly during her stay at the facility. Therapy services were offered and provided to the resident to prepare her to transition to a lower level of care (an assisted living facility). The resident was able to successfully transition to an assisted living facility in January of 2015 due to her improved physical functioning.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #6:

The facility did not manage an identified resident's pain, either through over- or under-medicating him/her.

FINDINGS:

The resident's clinical record was reviewed and staff was interviewed. The resident received as needed pain medication in addition to a pain patch (Fentanyl) which was started at 12.5 micrograms, then increased to 25 micrograms and then 50 micrograms in response to the resident's need for pain management. Although the resident did have documented episodes of pain, his/her response to administration of as needed medication in addition to her round the clock pain medication was positive.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #7:

The Reporting Party stated an identified resident's pain patch was contra-indicated with other medication the resident was receiving.

FINDINGS:

The resident's clinical record was reviewed and indicated the resident's physician and the facility pharmacy consultant routinely reviewed the resident's medication regime for potentially dangerous interactions to determine that the benefit of the medications outweighed risks to the resident.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #8:

The Reporting Party stated the facility did not respond to symptoms indicating an identified resident had developed a blood clot in his/her legs.

**FINDINGS:**

The identified resident's clinical record was reviewed and indicated that, although the resident did suffer from blood clots in both legs in September 2015, the facility evaluated the signs and symptoms quickly and the resident ' s physician ordered appropriate tests and placed the resident on appropriate medications within an appropriate time frame. The clots resolved prior to the resident ' s discharge from the facility.

**CONCLUSIONS:**

Unsubstantiated. Lack of sufficient evidence.

**ALLEGATION #9:**

The Reporting Party stated an identified resident's diet was too restrictive, causing poor nutritional intake and weight loss.

**FINDINGS:**

The resident's clinical record was reviewed and indicated the resident was placed on a full liquid diet per the request of her family and then, later when the resident's status improved, was graduated to a regular dysphagia diet. The record indicated the resident's family was involved with this decision making and granted permission to place the resident on this diet

**CONCLUSIONS:**

Unsubstantiated. Lack of sufficient evidence.

**ALLEGATION #10:**

The Reporting Party stated the facility failed to protect an identified resident's heels from developing pressure sores.

**FINDINGS:**

The resident's clinical record was reviewed and indicated the resident was to have her heels floated, however since the resident was no longer in the facility at the time of the investigation, observations of the resident could not be made. Observations were made of residents in the facility at the time of the investigation who had similar orders to float heels in place and no

concerns were noted. Interviews were conducted with residents residing in the facility at the time of the investigation regarding floating their heels and no concerns were noted.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #11:

The Reporting Party stated the facility did not have enough linens to change an identified resident's sheets regularly.

FINDINGS:

Observations were made and interviews were conducted with residents (individually and in a group setting) and staff regarding the availability of linen, and no concerns were noted.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #12:

The Reporting Party stated an identified resident did not get bathed during the month of September, 2015.

FINDINGS: The allegation was substantiated, and cited at F 312.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION # 13:

The Reporting Party stated an identified resident's room did not have hot water available.

FINDINGS:

The allegation that the identified resident's room did not have hot water was substantiated, however no deficient practice was cited. An interview was conducted with the facility Maintenance Director, and Complaint Concern Logs from September 2015 were reviewed. The interview and concern log confirmed there had been a malfunction with the hot water delivery to

the resident's room. When the problem was made known to the facility, parts were ordered parts to fix the sink as well as plumbing in the building related to the reported issue. The problem was fixed in an appropriate time frame.

**CONCLUSIONS:**

Substantiated. No deficiencies related to the allegation are cited.

**ALLEGATION # 14:**

The Reporting Party stated an identified resident's family did not have the opportunity to discuss concerns with the physician.

**FINDINGS:**

The facility Director of Nursing and the resident's physician were interviewed and indicated the resident's physician was available in the facility six mornings per week from 6 a.m. to 9 a.m., and this had been the physician's schedule for at least two years prior to the investigation. The resident's clinical record was reviewed and indicated the resident's physician interacted with the resident's family regarding her care appropriately during her stay.

**CONCLUSIONS:**

Unsubstantiated. Lack of sufficient evidence.

**ALLEGATION # 15:**

The Reporting Party stated an identified resident was moved to a new room for facility convenience.

**FINDINGS:**

The resident's record was reviewed and the Business Office Manager was interviewed. Although the resident did move to a different room in the facility during her stay, the family signed the appropriate permission forms and the resident was provided with a private room in the facility until her discharge to an assisted living facility in January 2016. No resident/family concerns were noted in the record regarding the room change.

**CONCLUSIONS:**

Unsubstantiated. Lack of sufficient evidence.

Lori Bentzler, Administrator  
August 26, 2016  
Page 8 of 8

Based on the findings of the investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this findings letter, as it will be addressed in the provider's Plan of Correction.

If you have questions, comments or concerns regarding our investigation, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

Nina Sanderson, LSW, Supervisor  
Long Term Care

NS/lj



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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

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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](mailto:fsb@dhw.idaho.gov)

December 9, 2016

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

Provider #: 135104

Dear Ms. Bentzler:

On **July 28, 2016**, an unannounced on-site complaint survey was conducted at Twin Falls Center. The complaint was investigated in conjunction with the facility's on-site Recertification and State Licensure survey conducted from July 25, 2016 to July 28, 2016. The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00007217**

**ALLEGATION #1:**

An identified resident lost a large amount of weight due to poor quality of food.

**FINDINGS:**

Meals were observed. A test tray was sampled. Resident transfers were observed.

The identified resident's medical record was reviewed. Thirteen other residents' records were reviewed. The facility's Grievance file was reviewed. Resident Council minutes were reviewed. The facility's Incident and Accident and Abuse investigations were reviewed.

Three residents were interviewed. Several residents in the Group meeting were interviewed. One family member was interviewed. Several staff members were interviewed.

Lori Bentzler, Administrator  
December 9, 2016  
Page 2 of 4

The identified resident was no longer residing the facility at the time the complaint was investigated.

Several residents were observed for food intake and assistance with meals and no concerns were identified.

The identified resident's medical record did not document an issue with weight loss. Six other residents' records were reviewed for weight loss and no concerns were identified.

Three residents and one family did not identify weight loss as a concern. A charge nurse, the dietary manager and the Registered Dietician said there was not a concern regarding the resident's weight.

Based on observations, record review, resident, family and staff interview, it was determined the allegation could not be substantiated.

**CONCLUSIONS:**

Unsubstantiated. Lack of sufficient evidence.

**ALLEGATION #2:**

The facility was serving unpalatable food of questionable quality.

**FINDINGS:**

Based on observation, record review, resident, family and staff interviews, it was determined the facility's menu lacked variety; was developed by persons unfamiliar with local food customs and preferences; and offered only minimal opportunity for resident input. The facility was cited at F363.

**CONCLUSIONS:**

Substantiated. Federal deficiencies related to the allegation are cited.

**ALLEGATION #3:**

Mechanical lift transfers were painful due to being 'drug out of bed.'

**FINDINGS:**

Several resident transfers were observed and no concerns were identified.

The identified resident's medical record was reviewed and no transfer concerns were identified. Several other residents' records were reviewed and no transfer concerns were identified. The facility's Incident and Accident and Abuse investigations were reviewed and no transfer concerns were identified.

Several residents in the Group meeting were interviewed and no transfer concerns were identified. A charge nurse and a social worker said they did not receive any complaints regarding the identified resident's transfers.

Based on observation, record review, resident and staff interview, it was determined the allegation could not be substantiated.

**CONCLUSIONS:**

Unsubstantiated. Lack of sufficient evidence.

**ALLEGATION #4:**

The resident was not seen by a physician while in the facility.

**FINDINGS:**

The identified resident's medical record was reviewed and no concerns for physician's visits were identified. Thirteen other residents' records were reviewed and no concerns for physician's visits were identified.

Several residents in the Group meeting were interviewed and no concerns for physician's visits were identified. A charge nurse said she observed the physician visit the resident once or twice during his/her stay.

Based on record review, resident and staff interview, it was determined the allegation could not be substantiated.

**CONCLUSIONS:**

Unsubstantiated. Lack of sufficient evidence.

Lori Bentzler, Administrator  
December 9, 2016  
Page 4 of 4

Based on the findings of the investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this findings letter, as it will be addressed in the provider's Plan of Correction.

If you have questions, comments or concerns regarding our investigation, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

A handwritten signature in cursive script that reads "Nina Sanderson LSW".

Nina Sanderson, L.S.W., Supervisor  
Long Term Care

NS/lj



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor  
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PHONE: (208) 334-6626  
FAX: (208) 364-1888  
E-mail: [fsb@dhw.idaho.gov](mailto:fsb@dhw.idaho.gov)

March 17, 2017

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

Provider #: 135104

Dear Ms. Bentzler:

On **July 28, 2016**, an unannounced on-site complaint survey was conducted at Twin Falls Center.

The complaint was investigated in conjunction with the facility's on-site Recertification and State Licensure survey conducted from July 25, 2016 to July 28, 2016.

Call light wait times were observed. Catheter care was observed. Fall precautions were observed.

The identified resident's medical record was reviewed and 12 other residents' records were reviewed. The facility's Grievance file, Resident Council minutes, and Incident and Accident Reports were also reviewed.

Three residents were interviewed individually, several residents in the Group meeting were interviewed, one family member was interviewed, and several staff members were interviewed.

The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00006907**

ALLEGATION #1:

The Reporting Party said staff did not respond to an identified resident's call light in a timely manner and a family member had to help clean up the resident who was soiled. The resident's catheter bag was also not emptied when it was full.

FINDINGS #1:

Based on observation, record review, and resident and staff interview, the allegation was substantiated for other residents and the facility was cited at F244.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #2:

An identified resident will not use his/her call light after being talked to by a staff member.

FINDINGS #2:

The identified resident's call light was observed being used at least once during the survey.

The identified resident said he/she has no concerns using the call light.

Based on observation and resident interview, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

An identified resident was found about to fall out of bed.

FINDINGS #3:

The identified resident was observed for fall precautions throughout the survey and no concerns

Lori Bentzler, Administrator  
March 17, 2017  
Page 3 of 3

were identified. Fall precautions for five other residents were observed and no concerns were identified.

The identified resident's clinical record was reviewed and no issues with falls were identified. Five other residents' records were reviewed for fall precautions and no concerns were identified.

Three residents were interviewed and fall precautions was not identified as an issue. One family member said residents were always positioned appropriately.

Based on observations, record review, and resident and family interviews, it was determined the allegation could not be substantiated.

#### CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

Based on the findings of the investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this findings letter, as it will be addressed in the provider's Plan of Correction.

If you have questions, comments or concerns regarding our investigation, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

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

David Scott, R.N., Supervisor  
Long Term Care

DS/lj



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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

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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](mailto:fsb@dhw.idaho.gov)

April 11, 2017

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

Provider #: 135104

Dear Ms. Bentzler:

On **July 28, 2016**, an unannounced on-site complaint survey was conducted at Twin Falls Center. The complaint was investigated in conjunction with the facility's on-site Recertification and State Licensure survey conducted from July 25, 2016 to July 28, 2016.

Water temperatures were observed. Meal times were observed. A test tray was sampled. Call light wait times were observed. Residents' skin treatments were observed. Medication Pass was observed.

The identified resident's medical record was reviewed. Thirteen other residents' records were reviewed. The facility's Grievance File was reviewed. Resident Council minutes were reviewed.

Three residents were interviewed. Several residents in the Group meeting were interviewed. One family member was interviewed. Several staff members were interviewed.

The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00007170**

**ALLEGATION #1:**

The Reporting Party stated an identified resident did not have hot running water available in the sink in his/her room.

**FINDINGS:**

The identified resident was no longer residing in the facility at the time the complaint was investigated.

The allegation that the identified resident's room did not have hot water was substantiated, however no deficient practice was cited. An interview was conducted with the facility Maintenance Director, and Complaint Concern Logs from September 2015 were reviewed. The interview and concern log confirmed there had been a malfunction with the hot water delivery to the resident's room. When the problem was made known to the facility, parts were ordered to fix the sink as well as plumbing in the building related to the reported issue. The problem was fixed in an appropriate time frame.

**CONCLUSIONS:**

Substantiated. No deficiencies related to the allegation are cited.

**ALLEGATION #2:**

An identified resident's pain was not effectively managed.

**FINDINGS:**

Medication Pass was observed with no issues regarding pain medication administration.

The identified resident's clinical record did not document an issue with pain control. Eight other residents' records reviewed for pain control did not reveal a concern. The facility's Grievance File did not document issues with pain control. Resident Council minutes did not document issues with pain control.

Three residents were interviewed and did not voice concerns with pain control. Several residents in the Group Meeting did not voice a concern with pain control. One family member was interviewed and did not voice concerns with pain control. Several nurses said residents' pain was controlled.

Based on observation, record review, and resident, family and staff interview, it was determined the allegation could not be substantiated.

**CONCLUSIONS:**

Unsubstantiated. Lack of sufficient evidence.

**ALLEGATION #3:**

Residents must wait long periods of time to receive help from staff due to staff shortages.

Lori Bentzler, Administrator  
April 11, 2017  
Page 3 of 4

**FINDINGS:**

Based on record review, and resident and staff interviews, it was determined the allegation was substantiated for other residents and the facility was cited at F244.

**CONCLUSIONS:**

Substantiated. Federal deficiencies related to the allegation are cited.

**ALLEGATION #4:**

Residents who ate in their rooms had to wait long periods of time to receive their meals.

**FINDINGS:**

Meal times were observed to be served after the dining room was served without concerns.

The facility's Grievance File did not document room trays were a concern. Resident Council minutes did not document room trays were a concern.

Several residents who ate in their rooms did not express concerns about the delivery times. Several residents in the Group Meeting did not voice a concern about meal delivery times.

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

**CONCLUSIONS:**

Unsubstantiated. Lack of sufficient evidence.

**ALLEGATION #5:**

The food did not taste good, zucchini was served too many times a week, and food preferences were not honored.

**FINDINGS:**

Based on observation, record review, and resident, family and staff interviews, it was determined the allegation was substantiated and the facility was cited at F363.

Lori Bentzler, Administrator  
April 11, 2017  
Page 4 of 4

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #6:

An identified resident did not receive pressure ulcer treatment according to physician's orders.

FINDINGS:

Two other residents' skin treatments were observed and no issues were identified.

The identified resident's clinical record was reviewed and no concerns were identified. Two other residents' records with skin issues were reviewed and no concerns were identified.

Nurses involved in skin treatments were interviewed and no concerns were identified.

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

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

Based on the findings of the investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this findings letter, as it will be addressed in the provider's Plan of Correction.

If you have questions, comments or concerns regarding our investigation, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

A handwritten signature in black ink that reads "D. Scott". The signature is written in a cursive style.

David Scott, R.N., Supervisor  
Long Term Care

Lori Bentzler, Administrator  
April 11, 2017  
Page 5 of 4

DS/lj