



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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

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

February 7, 2017

Steve Gannon, Administrator  
Quinn Meadows Rehabilitation & Care Center  
1033 West Quinn Road  
Pocatello, ID 83202-2425

Provider #: 135136

Dear Mr. Gannon:

On **January 27, 2017**, a survey was conducted at Quinn Meadows Rehabilitation & Care Center by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be an isolated deficiency 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 **February 17, 2017**. Failure to submit an acceptable PoC by **February 17, 2017**, may result in the imposition of penalties by **March 13, 2017**.

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 **March 3, 2017 (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 **April 27, 2017**. A change in the seriousness of the deficiencies on **March 13, 2017**, may result in a change in the remedy.

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The remedy, which will be recommended if substantial compliance has not been achieved by **April 27, 2017** includes the following:

Denial of payment for new admissions effective **April 27, 2017**. [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 **July 26, 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 **April 27, 2017** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

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

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

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

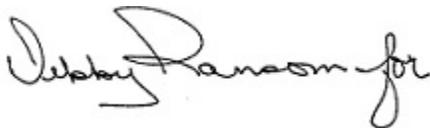
- BFS Letters (06/30/11)

2001-10 Long Term Care Informal Dispute Resolution Process  
2001-10 IDR Request Form

This request must be received by **February 17, 2017**. If your request for informal dispute resolution is received after **February 17, 2017**, 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 "Nina Sanderson for". The signature is written in a cursive style.

Nina Sanderson, LSW, Supervisor  
Long Term Care

NS/lj  
Enclosures

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

PRINTED: 02/21/2017  
FORM APPROVED  
OMB NO. 0938-0391

|   |   |   |   |                      |   |
|---|---|---|---|----------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>135136</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____  |                      | (X3) DATE SURVEY COMPLETED<br><br><b>C</b><br><b>01/27/2017</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>QUINN MEADOWS REHABILITATION &amp; CARE CENTER</b> |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1033 WEST QUINN ROAD<br/>POCATELLO, ID 83202</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 000   | INITIAL COMMENTS<br><br>The following deficiencies were cited during the complaint survey conducted at the facility January 26, 2017 through January 27, 2017.<br><br>The surveyors conducting the survey were:<br><br>Brad Perry, BSW, LSW, Team Coordinator<br>David Scott, RN<br>Marci Claire, RN<br><br>Survey Abbreviations:<br>ADL = Activities of Daily Living<br>cm = Centimeters<br>CNA = Certified Nursing Assistant<br>DON = Director of Nursing<br>LN = Licensed Nurse<br>LPM = Liters Per Minute<br>MAR = Medication Administration Record<br>MDS = Minimum Data Set assessment<br>PRN = As Needed<br>TX = Transfer<br>W/C = Wheelchair<br>w/o = Without | F 000   |   |                      |   |
| F 323<br>SS=D   | 483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br><br>(d) Accidents.<br>The facility must ensure that -<br><br>(1) The resident environment remains as free from accident hazards as is possible; and<br><br>(2) Each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>(n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side  | F 323   |   | 2/17/17              |   |

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

TITLE

(X6) DATE

Electronically Signed

02/14/2017

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 323   | <p>Continued From page 1</p> <p>or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.</p> <p>(1) Assess the resident for risk of entrapment from bed rails prior to installation.</p> <p>(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.</p> <p>(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by:<br/>Based on observation, record review, and resident, family and staff interviews, it was determined the facility failed to ensure a resident received sufficient supervision and that interventions initiated to prevent avoidable falls were followed. This was true for 1 of 2 residents (#2) sampled for falls. The deficient practice had the potential for harm if the falls resulted in a significant injury. Findings include:</p> <p>Resident #2 was admitted to the facility on 12/9/16, with multiple diagnoses including hip fracture.</p> <p>Resident #2's 12/9/16 and 12/16/16 Fall Risk Evaluations documented he was at high risk for falls.</p> <p>Resident #2's Fall Risk care plan documented a 12/9/16 intervention to keep his call light within reach.</p> | F 323   | <p>Preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the accuracy or truthfulness of any facts alleged or any conclusions set forth in this allegation of deficiencies by the State Licensing Authority.</p> <p>Accordingly, the facility has drafted this Plan of Correction in accordance with Federal and State Laws which mandate the submission of a Plan of Correction as a condition for participation in the Medicare and Medicaid program. This Plan of Correction shall constitute this facility's credible allegation compliance with this section.</p> <p>F- 323 SS=D</p> <p>¿483.25(d)(1)(2)(n)(1)-(3) <input type="checkbox"/> Free of</p> |                      |   |

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| F 323   | <p>Continued From page 2</p> <p>A 12/13/16 progress note documented Resident #2 was found on the floor with a 2.5 cm skin tear to his right outer hand.</p> <p>The 12/13/16 Incident and Accident form documented Resident #2 fell at 6:15 pm. The "Root Cause of This Fall" section documented Resident #2, "gets confused at night." The "Initial interventions to prevent reoccurrence" section documented, "...call light clipped to chest." The "Root Cause of Incident (Why did the incident happen?)" section documented, "Res[ident] did not use call light." The facility's intervention documented on the form was to educate Resident #2.</p> <p>Resident #2's 12/15/16, 5-day MDS assessment, documented he required extensive 2-person assistance for transfers.</p> <p>A 12/17/16 progress note documented Resident #2 fell; without injury, when attempting to get out of bed to go to the bathroom.</p> <p>Resident #2's 12/17/16 Incident and Accident form documented he fell at 5:30 pm. The mental status section documented, "resident gets confused at night." The "Root Cause of Fall" section documented "confusion." The "Initial interventions to prevent reoccurrence" section documented, "...Untied call light from bed rail and clipped to shirt." The "Root Cause of Incident (Why did the incident happen?)" section documented, "Self TX w/o call light use, confusion (Res[ident] does not always remember to call for help w/ call light.)" The facility's intervention was to add bed and wheelchair alarms.</p> | F 323   | <p>Accident Hazards/Supervision/Devices</p> <p>Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:</p> <p>Resident #2, on 1/16/2017 the Interdisciplinary Team determined that chair alarm and bed alarm were no longer necessary for this Resident, therefore the use of both chair alarm and bed alarm were discontinued.</p> <p>Resident #2, by 2/15/2017, Nursing staff on duty during the falls incident (who are currently employed in the facility), will be provided with 1:1 In-service education by the Director of Nursing or License Nurse Designee, regarding F-323, emphasizing the importance of making sure that all Resident(s) that are high risk for fall(s) receive sufficient supervision as specified in the care plan and that intervention(s) initiated to prevent avoidable fall(s) are being followed.</p> <p>Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken includes the following:</p> <p>This deficiency is an isolated deficiency</p> |                      |   |

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| F 323   | <p>Continued From page 3</p> <p>Resident #2's Fall Risk care plan documented 12/18/16 interventions of, "bed and tab alarm to alert staff to need [sic] assistance transferring."</p> <p>A 12/21/16 progress note documented Resident #2 fell at 4:30 pm, without injury.</p> <p>The 12/21/16 Incident and Accident form documented Resident #2 fell at 4:30 pm. The mental status section documented, "pleasant but confused, gets confused at night." The "Root Cause of This Fall" section documented "Alarm not clipped to shirt." The "Initial interventions to prevent reoccurrence" section documented, "Alarms reset, used urinal. Call light clipped to chest." The "Root Cause of Incident (Why did the incident happen?)" section documented, "Res[ident] ambulated his w/c away from call light, tried to stand up w/o assistance." The facility's intervention was to educate staff.</p> <p>Resident #2's 12/21/16 progress note documented he fell at 6:30 pm with a large skin tear to his left arm.</p> <p>Resident #2's 12/21/16 Incident and Accident form documented he fell at 6:30 pm and sustained three skin tears to the back of his arm. The mental status section documented, "He gets confused at night." The "Root Cause of the Fall" section documented, "Things that he needed (urinal) were out of reach." The initial interventions to prevent future falls section documented, "Put all things in reach of resident...and clipped call light to chest." The "Initial interventions to prevent reoccurrence" section documented, "Alarms reset, brought</p> | F 323   | <p>as reflected in the Statement of deficiencies-form CMS-2567.</p> <p>However, all current Resident(s) who are high risk for fall(s) may have the potential to be affected by this deficiency, therefore by 2/15/2017, the Administrator or Designee and Director of Nursing or License Nurse Designee will do a one time visual observation on all current Resident(s) who are high risk for fall(s) to ensure that resident(s) receives sufficient supervision as specified in the care plan and that intervention(s) initiated to prevent avoidable fall(s) are being followed.</p> <p>Measures that will be put into place or systemic changes you will make to ensure that the deficient practice does not recur includes the following:</p> <p>To ensure that the deficient practice does not recur:</p> <p>By 2/15/2017, the Director of Nursing or License Nurse Designee, will provide an Educational in-service training to all Nursing Staff regarding F-323, with emphasis on the importance of ensuring that all Resident(s) that are high risk for fall(s) receive sufficient supervision as specified in the care plan and that intervention(s) initiated to prevent avoidable fall(s) are being followed.</p> |                      |   |

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| F 323   | <p>Continued From page 4</p> <p>resident to nurses [sic] station to be watched." The "Root Cause of Incident (Why did the incident happen?)" section documented, "Res[ident] trying to TX to bathroom. No call light use, urinal out of reach according to Res." The facility's intervention was staff counseling/discipline provided.</p> <p>Resident #2's Fall Risk care plan documented 12/21/16 interventions of:<br/>-"Place/clip call light to p[atien]t clothing."<br/>-"Place table/fluids within reach."<br/>-"Keep urinal within reach."</p> <p>On 1/26/17 at 1:55 pm, Resident #2 was observed in bed to have the call light clipped to his shirt.</p> <p>On 1/26/17 at 1:55 pm, Resident #2's family member said she had expressed concerns to facility administration regarding the resident's falls and felt like they had not been adequately addressed. The family member also said prior to one of the falls, Resident #2's wheelchair alarm was not clipped to shirt, as ordered.</p> <p>On 1/27/17 at 10:15 am, Resident #2 said he could not remember the falls at the facility.</p> <p>On 1/27/17 at 12:35 pm, the DON said prior to Resident #2's first fall on 12/21/16, his wheelchair alarm was not clipped to his shirt, as the care plan directed. She said after that fall, and prior to the fall two hours later, she was not sure why Resident #2's call light was not clipped to his clothing as the immediate intervention indicated. The DON said on the second fall on 12/21/16 Resident #2's urinal was out of reach and she</p> | F 323   | <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</p> <p>Monitoring will be done through:</p> <p>The Administrator or Designee will do a visual observation of least three (3) random current Residents who are high risk for fall(s) to ensure that resident(s) receive sufficient supervision as specified in the care plan and that intervention(s) initiated to prevent avoidable fall(s) are being followed.</p> <p>Monitoring will start on 2/16/2017. This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3.</p> <p>The Administrator or designee will present to the quarterly QA&amp;A Committee meeting the findings and/or corrective actions taken.</p> <p>Compliance, continuation/discontinuation of monitoring will be discussed during the QA&amp;A Committee quarterly meeting.</p> |                      |   |

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

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FORM APPROVED  
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| F 323   | Continued From page 5<br>would expect staff to place it where he could reach it. The DON said she was not sure why the intervention to clip the call light to Resident #2's shirt had not been placed on his care plan, until after the four falls. The DON said the facility had recognized Resident #2 experienced confusion in the evenings and had initiated hourly checks, but the checks had not been added to his care plan as an intervention.  | F 323   |   |                      |   |
| F 328<br>SS=D   | 483.25(b)(2)(f)(g)(5)(h)(i)(j) TREATMENT/CARE FOR SPECIAL NEEDS<br><br>(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must:<br><br>(i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and<br><br>(ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments<br><br>(f) Colostomy, ureterostomy, or ileostomy care. The facility must ensure that residents who require colostomy, ureterostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences.<br><br>(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to ... prevent complications of enteral feeding including but not limited to aspiration pneumonia, | F 328   |   | 2/17/17              |   |

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| F 328   | <p>Continued From page 6</p> <p>diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers.</p> <p>(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences.</p> <p>(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.</p> <p>(j) Prostheses. The facility must ensure that a resident who has a prosthesis is provided care and assistance, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, to wear and be able to use the prosthetic device.</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Based on record review and staff interview, it was determined the facility failed to ensure oxygen therapy was provided as ordered by the physician and documented on his care plan. This was true for 1 of 4 sampled residents (Resident #6) reviewed for oxygen therapy. Resident #6 was exposed to potential harm when the facility failed to provide oxygen as physician ordered. Findings include:</p> | F 328   | <p>F- 328 SS=D</p> <p>§483.25(b)(2)(f)(g)(5)(h)(i)(j)<br/>Treatment/Care for Special Needs</p> <p>Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:</p> |                      |   |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>135136</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____  |                      | (X3) DATE SURVEY COMPLETED<br><br><b>C</b><br><b>01/27/2017</b> |
|---|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER<br><br><b>QUINN MEADOWS REHABILITATION &amp; CARE CENTER</b> |  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1033 WEST QUINN ROAD<br/>POCATELLO, ID 83202</b>  |                      |   |
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| F 328   | Continued From page 7<br><br>Resident #6 was admitted to the facility on 7/20/16, with diagnoses of chronic respiratory failure, obstructive sleep apnea, chronic obstructive pulmonary disease, and asthma.<br><br>An Admission Assessment, dated 7/20/16, documented Resident #6 was to receive oxygen therapy at a continuous rate of 5 liters per minute [LPM] via nasal cannula.<br><br>Resident #6's Medications with Associated Diagnosis Admit Form, dated 7/21/16, documented staff were to provide "oxygen [at] 5 LPM per nasal cannula [for] hypoxia."<br><br>An Admission Plan of Care for Oxygen, dated 7/20/16, did not include a related diagnosis for Resident #6's use of oxygen, but directed staff to:<br>* "Administer oxygen per MD order."<br>* "[Measure] oxygen saturation per facility standard, report abnormalities to MD with follow up as needed."<br>* "Observe resident [#6] for shortness of breath [and or] hypoxia. Notify physician and treat as ordered."<br><br>A "Late Entry" Nurse's Note, dated 8/29/16 "for 7/20/16," did not include documentation related to Resident #6's oxygen physician orders or oxygen care plan.<br><br>The July 2016 MAR documented Resident #6 received available oxygen via "room air," rather than the 5 LPM oxygen therapy ordered by the physician, each day, evening, and night shift during his stay at the facility from 7/21/16 through 7/25/16. Blood-oxygen saturation rates, all in the | F 328   | Resident # 6 is no longer a Resident of the facility.<br><br>Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken includes the following:<br><br>This deficiency is an isolated deficiency as reflected in the Statement of deficiencies-form CMS-2567.<br><br>However, all current Resident(s) who have continuous oxygen order may have the potential to be affected by this deficiency, hence by 2/15/2017, the Administrator or Designee and Director of Nursing or License Nurse Designee will do a one time review of all current Resident(s) who have an order for continuous oxygen to ensure that continuous oxygen therapy is provided as ordered by the physician, and documentation in their care plan includes related diagnosis for the continuous oxygen order(s).<br><br>Measures that will be put into place or systemic changes you will make to ensure that the deficient practice does not recur includes the following: |                      |   |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>135136</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____  |                      | (X3) DATE SURVEY COMPLETED<br><br><b>C</b><br><b>01/27/2017</b> |
|---|---|---|---|----------------------|---|
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| F 328   | <p>Continued From page 8</p> <p>90-percentile range, were also recorded on the July 2016 MAR through the 7/25/16 night shift.</p> <p>On 7/25/16 at 2:10 pm, Resident #6 was sent to a hospital for evaluation when his blood-oxygen saturation rates dipped into the "70s" percentage range, according to a Physician's Telephone Order.</p> <p>The 7/25/16 hospital Emergency Department Admission Report documented Resident #6's blood oxygen saturation level as 68 percent on room air. The Admission Report documented Resident #6 was admitted to the hospital's ICU with diagnoses of acute respiratory failure with hypoxia and pneumonia.</p> <p>Blood-oxygen saturation rates indicate the amount of oxygen bound to the blood's hemoglobin and delivered to the body's tissues to maintain homeostasis, according to Medical-Surgical Nursing, 6th edition, by Lewis, Heitkemper, and Dirksen. The mayoclinic.org website, accessed on 2/6/17, states, "Normal pulse oximeter readings usually range from 95 to 100 percent. Values under 90 percent are considered low."</p> <p>On 1/27/17 at 10:25 am, the DON stated Resident #6's blood-oxygen saturation rates "should" have been measured as the resident was receiving oxygen "especially if it's [ordered by the physician to be] continuous." When shown Resident #6's July 2016 MAR, the DON stated, "It looks like they [facility staff] took SATs [blood-oxygen saturation rates] on room air."</p> <p>On 1/27/16 at 11:05 am, with the DON present, LN #1, who the DON identified as the staff</p> | F 328   | <p>To ensure that the deficient practice does not recur:</p> <p>By 2/15/2017, the Director of Nursing or License Nurse Designee, will provide an educational in-service training to all License Nurses regarding F-328, with emphasis on the importance of making sure that all Resident(s) who have an order for continuous oxygen are provided with continuous oxygen therapy as ordered by the physician, and documentation on their oxygen care plan includes related diagnosis for the continuous oxygen order(s).</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</p> <p>Monitoring will be done through:</p> <p>The Administrator or Designee will review at least three (3) random current Resident(s) who have an order for continuous oxygen to ensure that continuous oxygen therapy is provided as ordered by the physician, and documentation on their oxygen care plan includes related diagnosis for the continuous oxygen order(s).</p> <p>Monitoring will start on 2/16/2017. This will be done weekly x 4, then q 2 weeks x 4,</p> |                      |   |

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

PRINTED: 02/21/2017  
FORM APPROVED  
OMB NO. 0938-0391

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| F 328   | Continued From page 9<br>member who recorded several of the blood-oxygen rates on the July 2016 MAR, stated Resident #6 was "always" on room air rather than the physician-ordered 5 LPM of oxygen therapy.<br><br>On 1/27/16 at 12:10 pm, the DON stated Resident #6's clinical record did not include documentation related to his 7/25/16 condition or transfer to the hospital, but said the nurse who discharged him that day was enroute to the facility to document a "late entry" Nurse's Note regarding Resident #6's condition and transfer on 7/25/16. | F 328   | then monthly x 3.<br><br>The Administrator or designee will present to the quarterly QA&A Committee meeting the findings and/or corrective actions taken.<br><br>Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee quarterly meeting. |                      |   |



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

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

TAMARA PRISOCK—ADMINISTRATOR  
LICENSING & CERTIFICATION  
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February 17, 2017

Steve Gannon, Administrator  
Quinn Meadows Rehabilitation & Care Center  
1033 West Quinn Road,  
Pocatello, ID 83202-2425

Provider #: 135136

Dear Mr. Gannon:

On **January 27, 2017**, an unannounced on-site complaint survey was conducted at Quinn Meadows Rehabilitation & Care Center.

Immediately upon entering the facility on the first day of survey, the survey team conducted a facility-wide observation of call light response times by staff, a brief tour of the kitchen, and a noon meal observation.

The following facility reports were reviewed: Medication error reports for July 2016 through January 2017; call light audit reports for July 2016 through January 2017; dietary preference cards for all current residents as well as the identified resident; and Resident Council meeting minutes for July 2016 through January 2017.

The director of Nursing was interviewed for concerns related to quality of care and resident rights. Several staff members were interviewed for these same concerns.

The clinical records of the identified resident were reviewed regarding the identified concerns. Three other residents' clinical records were also reviewed regarding the identified allegations; no concerns with these records were identified.

The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00007362**

**ALLEGATION #1:**

The Reporting Party stated an identified resident "was in a lot of pain while waiting" for a pain-relief medication a physician ordered, but the facility did not provide it until approximately four hours after admission to the facility.

**FINDINGS:**

The identified resident's clinical records included a list of medications and associated diagnoses form that documented an order for Morphine Sulfate extended-release tablets, 60 mg., that the resident was to receive daily for pain at 6:00 a.m. and 6:00 p.m. The order was dated July 21, 2016. The list of medications and associated diagnoses form also included physician orders for an antispasmodic for muscle spasms, which are often quite painful, and an analgesic to address, mild, moderate, and severe pain.

The July 2016 Narcotic Record documented the identified resident, who was admitted to the facility on July 20, 2016, received the first dose of Morphine Sulfate, which was delivered to the facility on July 22, 2016 at 2:50 a.m., that morning at 7:00 a.m., and the medication was administered at the scheduled times for the remainder of the resident's stay at the facility. The identified resident's Medication Administration Record documented non-pharmacological interventions to relieve pain were provided daily throughout the resident's stay and the physician-ordered analgesic for mild, moderate, and severe pain was administered daily from July 20, 2016 through July 23, 2016.

This allegation was substantiated. However there were no violations of federal regulation identified related to a delay in the delivery of the physician-ordered Morphine Sulfate or that the facility failed to address the identified resident's pain through the administration of other physician-ordered analgesics.

**CONCLUSIONS:**

Substantiated. No deficiencies related to the allegation are cited.

**ALLEGATION #2:**

The Reporting Party stated the resident's safety was endangered when the facility failed to provide bed siderails in a timely manner.

**FINDINGS :**

The identified resident's clinical record included a physician's order, dated July 20, 2016, for bilateral full-length bed siderails per family request to keep the resident, who experienced seizure activity, safe while in bed. A Physical Assistive Device Consent for Use form for bilateral half-siderails to the bed was signed by the identified resident's interested party on July 20, 2016, following a fall risk evaluation in which the resident was determined to be at high risk for falls, and a siderail assessment that determined the siderails were both needed and safe for use by the resident.

The Director of Nursing stated the facility's beds are not equipped with full-length siderails, however this type of siderail was ordered; a Nurse Progress Note documented the identified resident's full-length siderails were delivered to the facility and attached to the resident's bed prior to 5:30 a.m. on July 21, 2016. There is no evidence that the identified resident was not adequately supervised by the facility from the time of admission to the time of his bed being equipped with the full-length siderails. This allegation is not substantiated for lack of evidence the identified resident was at risk of accident or injury.

**CONCLUSIONS:**

Unsubstantiated. Lack of sufficient evidence.

**ALLEGATION #3:**

The Reporting Party stated call lights were not answered by staff in a timely manner when an identified resident required assistance using a bedside urinal.

**FINDINGS:**

The survey team observed call light response times throughout the complaint survey and reviewed the facility's call light audit record. No concerns were identified.

This allegation is not substantiated for lack of evidence.

**CONCLUSIONS:**

Unsubstantiated. Lack of sufficient evidence.

**ALLEGATION #4:**

The Reporting Party stated an identified resident was sent to a hospital where he was admitted to the Intensive Care Unit when the facility failed to provide supplemental oxygen therapy as ordered by the resident's physician and directed in the resident's care plan.

**FINDINGS:**

This allegation was substantiated and the facility was issued with deficient practice citations at F328 and F514. Please see Federal Report 2567 for details.

**CONCLUSIONS:**

Substantiated. Federal and State deficiencies related to the allegation are cited.

**ALLEGATION #5:**

The Reporting Party stated an identified resident was provided foods at meals to which the facility was informed he was allergic.

**FINDINGS:**

Immediately upon entry into the facility, the survey team procured dietary preference cards identifying those foods residents prefer to receive and those items residents either prefer not to receive or to which they have experienced allergic reactions. These cards were procured for both the identified resident and each of the seventeen current resident identified in the dining room during this meal observation. There were no concerns with foods provided to current resident during the meal service observation.

In addition to the meal observation, the identified resident's dietary preference card used by kitchen staff to prepare the resident's meals and snacks accurately recorded the identified resident's preferences, food allergies, and dislikes as identified on the Nutritional Interview of July 22, 2016.

Many of the identified residents documented preferences and dislikes involved fruits (canned peaches, pears, pineapple, and grapes were acceptable), but the menus for July 20, 2016 through July 25, 2016 did not specify which specific fruits were served to residents.

Additionally, the facility's Dietary Manager and Chef stated dietary preferences and requirements are communicated to kitchen staff to ensure residents are not given foods they are allergic to or that they do not care to eat.

Steve Gannon, Administrator  
February 17, 2017  
Page 5 of 5

This allegation is not substantiated for lack of evidence.

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 cursive script that reads "Nina Sanderson (L.S.W.)".

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

NS/lj



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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March 1, 2017

Steve Gannon, Administrator  
Quinn Meadows Rehabilitation & Care Center  
1033 West Quinn Road,  
Pocatello, ID 83202-2425

Provider #: 135136

Dear Mr. Gannon:

On **January 27, 2017**, an unannounced on-site complaint survey was conducted at Quinn Meadows Rehabilitation & Care Center. The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00007439**

The complaint was investigated from January 26, 2017 through January 27, 2017.

Call light response times were observed throughout the survey. Residents were observed for pressure ulcer and fall risk preventions.

The clinical record of the identified resident was reviewed and eight other residents' records were reviewed for Quality of Care concerns. Documents reviewed included: The facility's Grievance file from July 2016 through January 2017; Resident Council minutes from July 2016 through January 2017; Incident and Accidents reports from July 2016 through January 2017; and facility staffing records from December 20, 2016 through January 2, 2017.

Several residents, CNAs, nurses, and the Director of Nursing were interviewed regarding Quality of Care concerns.

**Allegation #1:** The Reporting Party said an identified resident had several falls in the facility and fall prevention was not being implemented.

**Findings #1:** Based on observation, record review, and family and staff interview, it was determined the allegation was substantiated and the facility was cited at F323. Please see Federal Report 2567 for details.

**Conclusion #1:** Substantiated. Federal deficiencies related to the allegation are cited.

**Allegation #2:** The Reporting Party said the facility did not provide appropriate pressure ulcer prevention, or document the resident's skin condition on admit.

**Findings #2:** Four residents were observed for pressure ulcer precautions.

The clinical record documented the identified resident received appropriate repositioning, the heels were floated, an admission skin assessment was completed, and interventions were put into place to prevent pressure ulcers from developing. The record also documented the resident fell and sustained injuries a day prior to the discovery of a deep tissue injury to the heel.

The identified resident was observed receiving appropriate pressure ulcer prevention interventions while both in bed and a wheelchair.

Several nurses and CNAs said residents received appropriate pressure ulcer precautions. The Director of Nursing said the resident received appropriate care planning, pressure ulcer precautions, and equipment when necessary.

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

**Conclusion #2:** Unsubstantiated. Lack of sufficient evidence.

**Allegation #3:** The Reporting Party said that on December 25, 2016, there was not enough staff on shift to meet the identified resident's needs for activities of daily living.

**Findings #3:** Observations were made of call light response times, staff assisting residents during meal times, and staff assisting residents to toilet.

The clinical record documented that appropriate cares were provided on December 25, 2016. The work sheets documented appropriate staffing levels on December 25, 2016.

Several Nurses and CNAs stated residents consistently received assistance toileting every time they need help. The Director of Nursing stated the residents received appropriate assistance toileting, linen changes, and with all activities of daily living.

The care plan provided staff direction for the resident's preferred dining location, preferences, and toileting needs.

Observations of call light response times showed timely responses during the investigation.

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

**Conclusion #3:** Unsubstantiated. Lack of sufficient evidence.

**Allegation #4:** When an identified resident fell at the facility he/she had pain and swelling in his/her wrist and the facility waited several days before the wrist was x-rayed, and showed the wrist was fractured.

**Findings #4:** The clinical record of the identified resident documented the wrist was fractured prior to admission to the facility. The resident's clinical record did not document a concern regarding a delay in treatment. Eight other residents' clinical records did not document a concern regarding a delay in treatment.

The Director of Nursing said the identified resident's wrist was fractured prior to the resident's admission to the facility. The Director of Nursing said the resident was monitored after each fall and did not experience a delay in treatment.

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

**Conclusion #4:** Unsubstantiated. Lack of sufficient evidence.

**Allegation #5:** An identified resident's family and physician were not notified after a fall in the facility.

**Findings #5:** The identified resident's clinical record did not identify a concern regarding family and physician notification. The identified resident's fall accident reports did not identify a concern regarding family and physician notification. Eight other residents' clinical records did not identify concerns with family and physician notification.

The Director of Nursing said families and physicians were notified whenever a resident fell in the facility.

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

**Conclusion #5:** Unsubstantiated. Lack of sufficient evidence.

Steve Gannon, Administrator  
March 1, 2017  
Page 4 of 4

**Allegation #6:** An Interested Party's concerns were not addressed by the facility during care conferences and the facility was not helping in discharge planning needs.

**Findings #6:** The identified resident's clinical record, including care conference notes, were reviewed and no concerns were identified. Grievances from July 2016 through January 2017 were reviewed and no concerns were identified regarding grievance resolution or discharge planning needs.

The Director of Nursing said when the facility is made aware of resident and family concerns, those are addressed as quickly as possible. She also said the Social Worker helps arrange discharge planning needs, but each department is also involved in residents' discharge needs.

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

**Conclusion #6:** 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, RN, Supervisor  
Long Term Care

DS/pmt