

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

PRINTED: 12/26/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135104	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/15/2017
NAME OF PROVIDER OR SUPPLIER TWIN FALLS CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 674 EASTLAND DRIVE TWIN FALLS, ID 83301		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	<p>INITIAL COMMENTS</p> <p>A complaint investigation was conducted between 11/13/17 and 11/15/17. The facility was found to be in substantial compliance with all regulatory requirements.</p> <p>The team conducting the survey was:</p> <p>Brad Perry, LSW Jenny Walker, RN</p>	F 000			

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

TITLE

(X6) DATE

Electronically Signed

12/23/2017

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.



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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December 22, 2017

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

Provider #: 135104

Dear Ms. Bentzler:

On **November 15, 2017**, 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 follow-up survey conducted from November 13, 2017 to November 15, 2015.

Several residents were observed throughout survey for incontinent care, hydration, and therapy needs. Several nurses were observed assessing residents' medical conditions.

The clinical record of the identified resident and several other residents were reviewed for Quality of Care concerns. The facility's Grievance file, as well as Incident and Accident reports, were reviewed.

Several residents, interested parties, Certified Nursing Assistants, and nurses were interviewed regarding Quality of Care concerns. A Nurse Unit Manager, Physical Therapist, Director of Nursing, and Administrator were interviewed regarding various issues.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007614

ALLEGATION #1:

The Reporting Party said there were large amounts of blood in an identified resident's incontinent brief and, because staff failed to assess the resident's medical condition adequately, an Interested Party had to call emergency response for the resident to receive the care he/she needed.

FINDINGS #1:

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

Similar allegations were investigated during the Recertification and State Licensure survey from August 7, 2017 to August 11, 2017, and the facility was cited at F281 and F309. Please refer to federal 2567 report for details.

CONCLUSIONS:

Substantiated. No deficiencies related to the allegation are cited.

ALLEGATION #2:

An identified resident's physician was not notified of blood observed in the resident's incontinent brief.

FINDINGS #2:

The clinical record of the identified resident documented the resident's physician was notified of the resident's bleeding episode. Several other residents' records documented their physicians were notified when a change of condition occurred.

Several nurses said physicians were notified whenever a resident experienced a change of condition. A Nurse Unit Manager said the identified resident's physician was notified blood was discovered in the resident's brief.

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

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

An identified resident was severely dehydrated.

FINDINGS #3:

Several residents were observed throughout survey for hydration needs and no concerns were identified.

The identified resident's clinical record, including a local hospital emergency room record, did not document a concern regarding severe dehydration. Several other residents' records did not document concerns regarding dehydration.

Several residents said they had access to fluids and had no concerns of dehydration. Several Certified Nursing Assistants and nurses said they ensure residents are well hydrated. The Director of Nursing said the identified resident received the appropriate volume of fluids and was not dehydrated prior to a hospital admission.

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

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

An identified resident lost the ability to walk due to a lack of care.

FINDINGS #4:

Several residents were observed throughout survey participating in therapy.

The clinical record documented the identified resident's walking ability improved while in therapy. Several other residents' records documented no concerns with therapy. The facility's Grievance file did not document a concern regarding therapy goals or residents' therapy needs.

Several residents said they received therapy, which helped them reach their therapy goals. A Physical Therapist said he had worked with the identified resident and the resident had made consistent improvements in the ability to walk with a walker.

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

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

As none of the allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

A handwritten signature in cursive script that reads "Nina Sanderson (L.S.W.)".

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

NS/lj