



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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May 2, 2018

Tory Bosworth, Administrator
Gateway Transitional Care Center
527 Memorial Drive
Pocatello, ID 83201-4063

Provider #: 135011

Dear Mr. Bosworth:

On **April 12, 2018**, a survey was conducted at Gateway Transitional 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 actual 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.

Tory Bosworth, Administrator
May 2, 2018
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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 **May 14, 2018**. Failure to submit an acceptable PoC by **May 14, 2018**, may result in the imposition of penalties by **June 6, 2018**.

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 recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) include:

Civil Monetary Penalty

Denial of payment for new admissions effective **July 12, 2018**. [42 CFR §488.417(a)]

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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 **October 12, 2018**, if substantial compliance is not achieved by that time.

Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended.

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 Debby Ransom, RN, RHIT, Bureau Chief, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 5; 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 **July 12, 2018** 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:

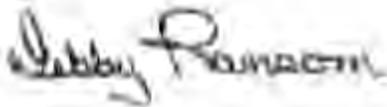
- BFS Letters (06/30/11)

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

This request must be received by **May 14, 2018**. If your request for informal dispute resolution is received after **May 14, 2018**, 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 Debby Ransom, RN, RHIT, Bureau Chief at (208) 334-6626, option 5.

Sincerely,



Debby, Ransom, RN, RHIT, Chief
Bureau of Facility Standards

dr/lj
Enclosures

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

PRINTED: 06/27/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135011	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/12/2018
NAME OF PROVIDER OR SUPPLIER GATEWAY TRANSITIONAL CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 527 MEMORIAL DRIVE POCATELLO, ID 83201		
(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 The following deficiencies were cited during the complaint survey conducted April 11, 2018 to April 12, 2018. The surveyors conducting the survey were: Teresa Kobza, RDN, LD, Team Coordinator Jenny Walker, RN Linda Kelly, RN ABBREVIATIONS: ADLs = Activities of Daily Living ADON = Assistant Director of Nursing BG = Blood Glucose CNA = Certified Nursing Assistant DNS = Director of Nursing Services IDT = Interdisciplinary Team IV = Intravenous therapy LPN = Licensed Practical Nurse MAR = Medication Administration Record MDS = Minimum Data Set mg = milligram PRN = Program For Recovering Nurses	F 000			
F 602 SS=D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by:	F 602		5/4/18	

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

TITLE

(X6) DATE

Electronically Signed

05/14/2018

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 602	<p>Continued From page 1</p> <p>Based on staff interview and review of policies, clinical records, employee time records, and facility investigations, it was determined the facility failed to ensure 1 of 7 sampled residents (#9) was free from misappropriation of a controlled pain medication. This failed practice resulted in misappropriation of Resident #9's Oxycodone by Staff #A. It also created the potential for other residents to experience uncontrolled pain if misappropriation of their controlled pain medications was undetected. Findings include:</p> <p>Resident #9 was admitted to the facility on 11/12/16 with multiple diagnoses, including end stage liver disease.</p> <p>A physician's order for Resident #9, dated 1/25/17, documented Oxycodone 10 mg every four hours as needed for pain. A subsequent physician's order documented Resident #9's Oxycodone 10 mg was discontinued on 11/21/17.</p> <p>Resident #9's November 2017 MAR included the order for Oxycodone 10 mg every four hours as needed for pain and that it was discontinued on 11/21/17. There was no documentation that Oxycodone was administered to Resident #9 in the November 2017 MAR.</p> <p>There was no documentation in the progress notes, dated 11/7/17 through 11/30/17, that Oxycodone was administered to Resident #9.</p> <p>Resident #9's narcotic count sheet, dated 11/14/17, documented 42 doses of Oxycodone 10 mg were delivered to the facility. The narcotic count sheet documented Staff #A signed that she</p>	F 602	<p>Narcotic Destruction:</p> <p>1a. Reviewed medication list to ensure all discontinued narcotics were destroyed appropriately</p> <p>2a. All Residents with controlled medications have the potential to be affected by the deficient practice. Corrective actions: Policy and Procedures updated to include all discontinued narcotics are to be disposed of per destructions policy, within 72 hours of discontinuation, or sooner. All licensed personnel in-serviced to updated policy.</p> <p>3a. Systemic changes are to initiate updated policy and procedure of destroying discontinued narcotics within 72 hours of discontinuation.</p> <p>4a. DNS / Designee will audit discontinued narcotics to ensure updated Policy and Procedures are being followed 3x/week for two weeks and weekly for 1 month. Monthly and PRN, thereafter.</p> <p>5a. Date of compliance 5/4/2018 _____</p> <p>Staff Member A:</p> <p>1b. Staff member A was suspended and later terminated.</p> <p>2b. This had the potential to affect all residents under the care of Staff member A. All staff in-serviced including DON /</p>		

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F 602	<p>Continued From page 2</p> <p>administered 15 of 16 doses between 11/14/17 and 11/20/17. One dose, dated 11/19/17 at 12:00 PM, documented different initials in the "Administered By" column, but was the same handwriting as Staff #A's in all the other documentation. After the Oxycodone was discontinued on 11/21/17, Staff #A signed that she administered 15 of 15 doses between 11/22/17 to 11/26/17. The narcotic count sheet documented 11 doses remained in the bubble pack card.</p> <p>An undated summary of the facility's investigation, signed by the Administrator, DNS, and ADON on 12/8/17, documented, "On 11/27/17 it was reported to the DNS that during an attempt to waste a discontinued narcotic, one of the medication cards on [Resident #9's name] had medications taped back into the card." The investigation documented [Staff A's name] "had signed out the medications to this resident and that the medications taped in did not correlate, in appearance, with what was described on the Pharmacy identification tag." The summary documented the remaining 11 doses in the bubble pack card were Melatonin, not Oxycodone.</p> <p>The investigation summary documented Staff #A was not available for interview until 11/30/17 at 2:00 PM. Staff #A admitted to taking Resident #9's Oxycodone and replacing the remaining 11 doses in the bubble pack card with Melatonin. The investigation documented Staff #A was taking the Oxycodone from Resident #9 for "personal use" since the beginning of November. Staff #A was suspended pending investigation.</p>	F 602	<p>ADON, that when an employee has had a history of diversion and while in an addiction recovery program they are to be assigned a workplace monitor who is fully aware of the employees restrictions and requirements as set forth by the program for recovering nurses and the Idaho State Board of Nursing. Staff also in-serviced the a recovering employee can not be in the building without a workplace monitor.</p> <p>Corrective actions taken are that staff member A was immediately suspended and not allowed access to the medications and later terminated.</p> <p>3b. Policy and Procedure has been created to include: Should the facility interview a clinician that has a history of drug diversion and is in a program for recovery, that potential employee must concede to allow fellow clinicians and management to be aware that they are in a program for recovery and have stipulations that must be followed. that potential employee must be assigned a work place monitor that has been made fully aware of the employees restrictions and requirements as set forth by the program for recovering nurses and the Idaho state board of nursing. the assigned work place monitor will follow up monthly with the PRN program to ensure the potential employee is following the program requirements consistently and is deemed safe to work. terms of employment will be such that the potential hire concedes to these requirements and</p>		

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F 602	<p>Continued From page 3</p> <p>The investigation summary documented, "Per the results of this investigation we feel this was an isolated incident that began in the beginning of November, involved one resident, and did not result in bodily harm or any adverse effect to the identified resident or other residents. The identified nurse was suspended, reported to the nursing board, and local Police were notified..."</p> <p>The investigation summary documented the Board of Nursing and the Police Department were both notified on 12/1/17, four days after the facility knew about the misappropriation of the controlled medication by Staff #A.</p> <p>The Bureau of Facility Standards Long Term Care Reporting System documented the facility notified the State Survey Agency on 12/1/17 at 11:25 AM, four days after the facility knew about the misappropriation of the controlled medication by Staff #A.</p> <p>On 4/11/18 at 1:00 PM, the facility provided a current employee job profile that listed Staff #A as an LPN.</p> <p>On 4/11/18 at 4:25 PM, the DNS stated Staff #A told him that she was in a program for recovering nurses. The DNS was unable to provide documentation about the recovering nurses program and was unaware of any restrictions or limitations for Staff #A. The DNS stated Staff #A returned to work under his supervision and her job duties entailed filing paperwork. The DNS stated Staff #A was not working as a nurse, was not providing direct patient care, did not have access to the electronic medication records, and did not have keys to access the medication carts</p>	F 602	<p>that employment cannot start until the facility has obtained confirmation from the PRN and the Idaho state board of nursing that the said potential employee is safe to return to work as a clinician under the set forth stipulations.</p> <p>the policy has also been updated to include that if a current employee is found to be diverting medications. that employee will immediately be suspended and or terminated if harm was verified. if harm was ruled out the suspension will continue pending investigation and the employee will be banned from the facility grounds unless under direct supervision by the administrator, DON or ADON or one appointed by the aforementioned management and only on reasons for questioning for the investigation. Law enforcement and The Bureau of Facility Standards will be notified within 2 hours after the allegation of a reasonable suspicion of a crime if the events that cause the allegation include abuse or resulted in serious bodily injury. If no serious bodily injury, then incident will be reported within 24 hours. Pending the investigation and the employees commitment to follow the requirements in the updated Policy and Procedure, that employee may return to work only after the stipulations described in the Policy are followed and verified by the DON or Administrator.</p> <p>4b. DNS / Designee will audit to ensure that the updated Policy and Procedure is followed for any staff in the PRN program.</p>		

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F 602	<p>Continued From page 4 or medication rooms.</p> <p>On 4/12/18 at 8:30 AM, the Administrator stated the facility did not press charges against Staff #A with the police department. The Administrator stated he did not have a copy of the police report and it would take 3 business days to get a copy of the police report.</p> <p>On 4/12/18 at 10:00 AM, the DNS provided a Program For Recovering Nurses (PRN) contract for Staff #A dated 1/7/18. The PRN contract documented, "I shall not return to work until I receive written approval from the PRN and support of my treatment provider. In the event that I change positions or seek new employment, I shall obtain approval from the PRN at least two weeks prior to accepting the position. To begin working, I must first have a work monitor in place and all releases must be signed for the hiring facility." The PRN contract was signed by Staff #A on 1/7/18 and a witness signed the contract five days later on 1/12/18. The DNS stated he did not have the PRN contract until 4/12/18 and he was unaware that written approval from the PRN program was required for Staff #A to return to work in any capacity. The DNS stated Staff #A filed paperwork in his office or the charge nurse room within the conference room and only worked when he was in the building.</p> <p>Staff #A's employee time record documented Staff #A worked 4-6 days per week between 2/12/18 to 4/9/18, including 3 Saturdays in March 2018 (3/17/18, 3/24/18, and 3/31/18).</p> <p>On 4/12/18 at 10:30 AM, the DNS stated he was not aware Staff #A had worked on Saturdays.</p>	F 602	<p>Audits will be 3x/week for two weeks and weekly for 1 month. Monthly and PRN, thereafter.</p> <p>5b. Date of compliance: 5/4/2018</p>		

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F 602	Continued From page 5 The DNS stated he was not in the building and Staff #A was not supervised on those dates.	F 602			
F 608 SS=D	Reporting of Reasonable Suspicion of a Crime CFR(s): 483.12(b)(5)(i)-(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. (i) Annually notifying covered individuals, as defined at section 1150B(a)(3) of the Act, of that individual's obligation to comply with the following reporting requirements. (A) Each covered individual shall report to the State Agency and one or more law enforcement entities for the political subdivision in which the facility is located any reasonable suspicion of a crime against any individual who is a resident of, or is receiving care from, the facility. (B) Each covered individual shall report immediately, but not later than 2 hours after forming the suspicion, if the events that cause the suspicion result in serious bodily injury, or not later than 24 hours if the events that cause the suspicion do not result in serious bodily injury. (ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. (iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and review of facility investigations and a police	F 608		5/4/18	
			1. Corrective actions for affected resident to ensure pain was controlled.		

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F 608	<p>Continued From page 6</p> <p>report, it was determined the facility failed to report misappropriation of a controlled medication to law enforcement within 24 hours. This was true for 1 of 7 residents (#9) whose medications were reviewed. The delay in reporting created the potential for misappropriation of controlled medication to continue without detection. Findings include:</p> <p>Resident #9 was admitted to the facility on 11/12/16 with multiple diagnoses, including end stage liver disease.</p> <p>A physician's order for Resident #9, dated 1/25/17, documented Oxycodone 10 mg every four hours as needed for pain. A subsequent physician's order documented Resident #9's Oxycodone 10 mg was discontinued on 11/21/17.</p> <p>An undated summary of a facility investigation, signed by the Administrator, DNS, and ADON on 12/8/17, documented, "On 11/27/17 it was reported to the DNS that during an attempt to waste a discontinued narcotic, one of the medication cards on [Resident #9's name] had medications taped back into the card." The investigation documented [Staff A's name] "had signed out the medications to this resident and that the medications taped in did not correlate, in appearance, with what was described on the Pharmacy identification tag." The summary documented the remaining 11 doses in the bubble pack card were Melatonin, not Oxycodone.</p> <p>The investigation summary documented the police department was notified on 12/1/17, four days after the misappropriation of Resident #9's</p>	F 608	<p>The suspected employee was suspended. Law enforcement was contacted.</p> <p>2. All residents have the potential to be affected by the deficient practice. Policy and Procedure updated to include: Reporting any reasonable suspicion of a crime no later than two hours after forming the suspicion, if the events that cause the suspicion result in serious bodily injury; or not later than 24 hours if the events that cause the suspicion do not result in serious bodily injury.</p> <p>3. Systemic measures put in place are that entire staff in-services to policy and procedure immediately and re-in-service 2x/year in conjunction with abuse training.</p> <p>4. DNS / Designee will audit the log for suspicious crimes to ensure Policy and Procedure is followed appropriately. Monitoring will be 3x/week for two weeks and weekly for 1 month.</p> <p>5. Date of compliance: 5/4/2018</p>		

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F 608	Continued From page 7 controlled medication by Staff #A was reported to the DNS on 11/27/17. On 4/16/18, the facility provided a Police Department Detail Incident Report, dated 12/1/17. The report documented a police officer responded to the facility regarding a reported theft of medication. The police report documented a police officer spoke to Staff #A on 12/2/17 and Staff #A, "...admitted to taking the pills between 11/14/17 and 11/17/17...she had taken at least eleven Oxycodone pills, possible [sic] more, though she did not remember the exact amount...she had taken the pills for personal use, and had already consumed them." The report documented the incident was forwarded to the narcotics division. The police report documented on 12/21/17 the narcotics division was not mandated to press a charge for the "theft" of the Oxycodone.	F 608			
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to	F 609		5/4/18	

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F 609	<p>Continued From page 8</p> <p>other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.</p> <p>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interview, review of facility investigations, and review of the Bureau of Facility Standards Long Term Care Reporting System, it was determined the facility failed to report misappropriation of a controlled medication to the State Survey Agency within 24 hours. This was true for 1 of 9 residents (#9) whose medications were reviewed. The delay in reporting created the potential for misappropriation of controlled medication to continue without detection. Findings include:</p> <p>Resident #9 was admitted to the facility on 11/12/16 with multiple diagnoses, including end stage liver disease.</p> <p>A physician's order for Resident #9, dated 1/25/17, documented Oxycodone 10 mg every four hours as needed for pain. A subsequent physician's order documented Resident #9's Oxycodone 10 mg was discontinued on 11/21/17.</p> <p>An undated summary of a facility investigation,</p>	F 609	<ol style="list-style-type: none"> 1. Corrective Actions for affected resident to ensure pain was controlled. The suspected employee was suspended. Law enforcement was contacted and well as the State Bureau of Facility Standards (BFS). 2. All residents have the potential to be affected by the deficient practice. Policy and Procedure updated to include: Reporting any reasonable suspicion of a crime no later than two hours after forming the suspicion, if the events that cause the suspicion result in serious bodily injury; or not later than 24 hours if the events that cause the suspicion do not result in serious bodily injury. 3. Systemic measures put in place are that the entire staff was in-serviced to policy and procedure immediately and in-service will continue 2x/year in conjunction with abuse training. 		

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F 609	Continued From page 9 signed by the Administrator, DNS, and ADON on 12/8/17, documented, "On 11/27/17 it was reported to the DNS that during an attempt to waste a discontinued narcotic, one of the medication cards on [Resident #9's name] had medications taped back into the card." The investigation documented [Staff A's name] "had signed out the medications to this resident and that the medications taped in did not correlate, in appearance, with what was described on the Pharmacy identification tag." The summary documented the remaining 11 doses in the bubble pack card were Melatonin, not Oxycodone. The Bureau of Facility Standards Long Term Care Reporting System documented the facility notified the State Survey Agency on 12/1/17 at 11:25 AM, four days after the facility knew about the misappropriation of the controlled medication by Staff #A.	F 609	4. DNS / Designee will audit a log for suspicious crime reporting to ensure Policy and Procedure is followed appropriately. Monitoring will be 3x/week for 2 weeks and weekly for 1 month 5. Date of compliance: 5/4/2018		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-	F 655		5/4/18	

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F 655	<p>Continued From page 10</p> <p>(A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable.</p> <p>§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-</p> <p>(i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).</p> <p>§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:</p> <p>(i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure a baseline care plan included the instructions needed to provide effective and person-centered care. This was true for 1 of 3 sample residents (#4) whose baseline care plans were reviewed. This deficient practice created the potential for Resident #4 to experience hyper/hypoglycemic</p>	F 655	<p>1. Corrective Actions for resident found to be affected: Care Plan has promptly been updated to instruct following physician orders and Policy and Procedure for diabetes management.</p> <p>2. All residents with DM have the potential to be affected by the deficient</p>		

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F 655	<p>Continued From page 11 (high/low blood sugar) events without the implementation of corrective interventions. Findings include:</p> <p>Resident #4 was admitted to the facility on 4/5/18 with multiple diagnoses, including diabetes mellitus.</p> <p>Resident #4's 4/2/18 hospital discharge medication list and the resident's April 2018 facility recapitulation of orders, documented the following medications for diabetes:</p> <ul style="list-style-type: none"> * insulin glargine solution 12 units by subcutaneous injection two times a day; * insulin lispro solution per sliding scale before meals and at bedtime, notify the physician if the resident's BG was less than 60 and if the BG was greater than 500, give 12 units of insulin and notify the physician; * Glucagon 1 mg by intramuscular injection as needed for hypoglycemia (low blood sugar). <p>Resident #4's care plan documented the potential for nutritional problems related to diabetes. The care plan did not include further reference or interventions related to diabetes.</p> <p>On 4/12/18 at 9:15 AM, the DNS provided the facility's Diabetic Protocol policy and procedure, revised October 2017, which documented the following:</p> <ul style="list-style-type: none"> * Call the physician if the diabetic resident has a fever, low blood pressure, lethargy or confusion, abdominal or chest pain, respiratory distress, or 	F 655	<p>practice. Corrective actions: All residents with DM will have the Care Plans reviewed to ensure instructions to follow Physician orders and diabetic policy are in place.</p> <p>3. Systemic changes include: All licensed personnel in-services to include within 48 hours Care Plans with instructions to follow Physician orders and diabetic policy for all residents admitted with a diagnosis of DM.</p> <p>4. DNS / Designee will audit new admissions with diagnosis of DM to ensure instruction to follow Physician orders and DM policy are care planned within 48 hours. This will be done 3x/week for two weeks and weekly for 1 month. Monthly and PRN, thereafter.</p> <p>5. Date of compliance 5/4/2018</p>		

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F 655	<p>Continued From page 12 functional and/or mental decline.</p> <p>* If the BG is 0-65 and the resident is conscious and able to swallow: give juice, 2% milk or 1 pouch of glucose gel combined with a protein snack, notify the supervisor, recheck the BG in 15 minutes, repeat the intervention and BG check 15 minutes later if the BG is still less than 65 and the resident is alert, notify the physician non-urgently versus STAT (immediately), if the resident becomes unresponsive at any time or becomes extremely lethargic call 911.</p> <p>* If the BG is 0-65 and the resident is unconscious or unable to swallow: give Glucagon 1 mg by subcutaneous or intramuscular injection, notify the physician "STAT" and notify your supervisor, recheck the BG in 15 minutes, if BG still less than 60 call 911, if BG 65 or over and resident is conscious and talking, offer a protein snack, recheck the BG in 1 hour and resume previous testing orders.</p> <p>* If the blood sugar is over 500: give the maximum units of insulin per the sliding scale orders, notify the physician, recheck the blood sugar in 1 hour, and follow new orders if they are given.</p> <p>* If the blood sugar is over 600: give the maximum units of insulin per the sliding scale orders, notify the physician, recheck the blood sugar in 1 hour, if still "Hi" notify the physician and do a BMP (basic metabolic profile lab test) STAT, and follow new orders if they are given.</p> <p>On 4/12/18 at 5:40 PM, the ADON said residents who are diabetic should have a care plan for</p>	F 655			

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F 655	Continued From page 13 diabetes from the beginning of their stay in the facility.	F 655			
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the	F 656		5/4/18	

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F 656	<p>Continued From page 14</p> <p>community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.</p> <p>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff interview, it was determined the facility failed to implement comprehensive resident-centered care plans. This was true for 2 of 4 (#3 and #6) residents reviewed for diabetes management care plans and had the potential for harm if residents experienced hyper/hypoglycemic (high/low blood sugar) events. Findings include:</p> <p>1. Resident #3 was admitted to the facility on 2/5/18 with diagnoses, including diabetes mellitus.</p> <p>An admission MDS assessment, dated 2/12/18, documented Resident #3 was cognitively intact and required extensive assistance of 1-2 staff members for cares.</p> <p>The care plan addressing diabetes mellitus, dated 2/20/18, documented signs and symptoms of hypoglycemia and hyperglycemia. The care plan did not include instructions for staff on how to treat hypoglycemic events or hyperglycemic events.</p> <p>On 4/12/18 at 5:35 PM, the ADON stated the care plan should have documented staff were to follow the facility's diabetic protocol. The ADON stated the diabetic protocol was located on the</p>	F 656	<p>1. Corrective actions for residents affected were: Care Plans were reviewed and updated to include following instructions in Physician orders and Policy and Procedures for DM.</p> <p>2. All residents with a diagnosis of DM have the potential to be affected. All residents with a diagnosis of DM will have care plans reviewed and updated to include following instructions found in Physician Orders. Policy and Procedures.</p> <p>3. Systemic changes to include: All licensed personnel will be in-serviced to include in care plan of residents diagnosed with DM instructions found in Physician orders and in DM Policy and Procedure.</p> <p>4. DNS / Designee will Audit random Care Plans to ensure Physician orders and Diabetic Policy and Procedure are in Care Plan (DM Policy instruct hypo/hyper-glycemia). This will be done 3x/week for two weeks. Weekly for 1 month. Monthly and PRN, thereafter.</p>		

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F 656	Continued From page 15 nursing medication carts for all the nurses to reference. 2. Resident #6 was admitted to the facility in 2016 and readmitted on 3/9/18 with multiple diagnoses, including diabetes mellitus. The care plan addressing diabetes mellitus, dated 3/7/18, documented staff were to assess Resident #6 for signs of skin breakdown and provide diabetic medications as ordered. The care plan did not include instructions for staff on how to treat hypoglycemic or hyperglycemic events and the symptoms of hypoglycemia and hyperglycemia staff were to monitor for. On 4/12/18 at 5:35 PM, the ADON stated the care plan should have documented staff were to follow the facility's diabetic protocol.	F 656	5. Date of Compliance: 5/4/2018		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of policies, resident records, facility investigations, it was determined the facility failed to ensure professional standards of practice for medication management were followed for 3 of 9	F 684	(#1) 1a. Resident affected by deficient practice has since been discharged home	5/4/18	

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F 684	<p>Continued From page 16</p> <p>sample residents (#3, #8, and #9) whose medications were reviewed. Resident #8 continued to receive an IV antibiotic after she may have experienced an allergic reaction to the medication. Resident #9's narcotic medication was discontinued and not destroyed in a timely manner, which contributed to the misappropriation of Resident #9's narcotic medication. Resident #3 did not receive ordered IV antibiotic medications, placing her at risk of ineffective antibiotic therapy. Findings include:</p> <p>1. Resident #8 was admitted to the facility on 1/28/18 with diagnoses including pancreatic cancer and staphylococcal arthritis (septic/infectious arthritis).</p> <p>An admission MDS assessment, dated 2/4/18, documented Resident #8 was cognitively intact and received IV antibiotics.</p> <p>a. Resident #8 began a six-week treatment of IV antibiotics, vancomycin, on 1/19/18 prior to admission to the facility. The facility continued to administer vancomycin to Resident #8 after she experienced possible signs and symptoms of an allergic reaction to the antibiotic as follows:</p> <p>The care plan addressing Resident #8's septic arthritis, dated 1/29/18, documented staff members were to obtain and monitor her lab work, as ordered, and report these results to the Infectious Disease (ID) physician. The care plan documented Resident #8 was on IV vancomycin for the infection.</p> <p>Physician orders documented, from 1/28/18 through 3/4/18, Resident #8 received daily doses</p>	F 684	<p>2a. All residents have the potential to be affected by the deficient practice. All licensed staff in-serviced to include holding a medication if signs and symptoms of allergic reactions occur to then notify the physician of a possible reaction. Also in-serviced as to possible signs/symptoms of medications allergic reactions.</p> <p>3a. Systemic changes include updating policy and procedure to include holding medications if signs and symptoms of allergic reactions occur. All licensed personnel in-serviced to updated policy.</p> <p>4a. DNS / Designee will randomly interview licensed staff to ensure they are following the updated policy and procedure for allergic reaction to medication. This will occur 3x/week for two weeks. Weekly for 1 month. Monthly and PRN, thereafter.</p> <p>5a. Date of compliance 5/4/2018 _____</p> <p>1b. Residents affected by the deficient practice have been discharged.</p> <p>2b. All residents that have had allergic reactions to medications have the potential to be affected by the deficient practice. All licensed staff in-serviced to notify the Physician anytime interventions cannot be fully implemented with allergic reactions.</p>		

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F 684	<p>Continued From page 17 of IV vancomycin, varying from 450 mg to 500 mg, for sepsis.</p> <p>Resident #8's MAR documented vancomycin was administered and vancomycin lab test results were completed as ordered by the ID physician from 1/28/18 through 3/4/18. During this period, Progress Notes included communication from the Nurse Practitioner (NP) to nursing staff, dated 2/20/18 at 10:30 AM, Resident #8 had a bilateral rash and swelling to her lower extremities that may be related to a possible reaction to vancomycin. The NP documented he would re-assess the rash after the vancomycin was discontinued and after Resident #8 finished a 5-day course of prednisone. The NP did not suggest stopping the vancomycin at that time. The communication documented the NP also ordered as needed Benadryl. There was no documentation the NP nor facility staff notified the ID physician of Resident #8's 2/20/18 possible reaction to the vancomycin.</p> <p>A 2/21/18 Progress Note documented the NP evaluated Resident #8 and "noted that she had a rash to lower extremities that might be reaction to an ABX [antibiotic]." There was no documentation the facility reported the possible allergic reaction from the vancomycin to the ID physician at that time.</p> <p>A Progress Note, dated 3/2/18 at 5:20 AM, documented Resident #8 continued to receive vancomycin and "continues to have a rash on legs and arms."</p> <p>Two Progress Notes, dated 3/2/18 at 11:10 AM and 3/5/18 at 12:22 PM, documented Resident</p>	F 684	<p>3b. Measures and systemic changes done are Policy and Procedures were updated to include directions to notify Physician anytime interventions cannot be fully implemented with allergic reactions. All licensed staff will be in-serviced to updated policy.</p> <p>4b. DNS / Designee will randomly interview licensed staff to ensure physician properly notified when interventions cannot be fully implemented with allergic reactions. This will occur 3x/week for two weeks. Weekly for one month. Monthly and PRN, thereafter.</p> <p>Date of compliance: 5/4/2018</p> <p>_____</p> <p>(#2)</p> <p>1. Resident affected by deficient practice was evaluated for further signs and symptoms of infection and physician was notified. Treatment for infection was continued.</p> <p>2. All residents receiving I.V. medication have the potential to be affected by the deficient practice. Licensed staff in-serviced. When signing in I.V. medications, the nurse signing for them, ensures they are delivered and placed in the refrigerator of the assigned med room.</p> <p>3. Measures and systemic changes</p>		

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F 684	<p>Continued From page 18</p> <p>#8 was administered 25 mg of as needed Benadryl for a rash and itchiness.</p> <p>There was no documentation the facility reported the possible allergic reaction from the vancomycin to the ID physician when signs and symptoms were identified on 3/2/18.</p> <p>A Progress Note, dated 3/6/18 at 2:03 PM, documented staff were to monitor Resident #8 for adverse side effects of vancomycin related to increased edema (excess fluid buildup), rash, and pain every 8 hours for 72 hours and report the results to the physician. The note documented Resident #8 was sent to the emergency room for evaluation related to possible signs and symptoms of side effects to vancomycin.</p> <p>A Progress Note, dated 3/6/18 at 5:52 PM, documented Resident #8 had non-pitting edema located on her right arm and around the left side of her face. The note documented it was possibly related to vancomycin. The note documented Resident #8 had acute pain, a rash to all extremities, itching, and edema. The note documented Resident #8 was admitted to the hospital for evaluation of the adverse reaction to the medication.</p> <p>A Progress Note, dated 3/6/18 at 5:57 PM, documented the facility notified the NP on 3/5/18 at 7:00 AM of a change in condition of new or worsening edema to Resident #8.</p> <p>A 3/8/18 Progress Note documented the following communications between a nurse and the NP between 3/5/18 and 3/8/18. A summary of</p>	F 684	<p>include updating Policies and Procedures to include direction for when signing in I.V. medications and the nurse signing for them ensures medications are delivered and placed in the refrigerator of the assigned med room. All licensed staff in-serviced to updated Policy and Procedure.</p> <p>4. DNS / Designee will audit delivery of I.V. medications to ensure licensed nurses are following updated policy. This will be monitored 3x/week for two weeks; weekly for one month. Monthly and PRN, thereafter.</p> <p>5. Date of Compliance: 5/4/2018</p> <p>_____</p> <p>(#3)</p> <p>1. Corrective Actions for residents affected by the deficient practice include: Destruction of discontinued narcotic medication and pain assessments performed.</p> <p>2. All residents receiving narcotic medications have the potential to be affected. All licensed staff in-serviced to dispose all discontinued narcotics as soon as possible but no later than 72 hours.</p> <p>3. Systemic changes include initiate Policy and Procedures of disposing all discontinued narcotic medications. All</p>		

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F 684	<p>Continued From page 19</p> <p>the LPN #1's communication on 3/5/18 at 1:31 PM, documented Resident #8 had a 6.4 critical lab value of potassium. A summary of LPN #1's communication on 3/5/18 at 3:28 PM, documented Resident #8 was having side effects from the vancomycin and the LPN was trying to contact the ID physician for instructions for what to do with the vancomycin order. A summary of LPN #1's communication on 3/5/18 at 4:23 PM, documented the ID physician's office was contacted about the signs and symptoms and they were relayed to the ID physician. The communication documented the office was "under the impression the vancomycin was supposed to end on 3/2 but our orders end 3/6." A summary of LPN #1's communication on 3/5/18 at 4:24 PM, documented the ID physician agreed to hold the vancomycin and ordered Benadryl and dexamethasone. A summary of LPN #1's communication on 3/6/18 at 7:01 PM, documented Resident #8's potassium level was elevated to 6.6. A summary of the NP's communication on 3/8/18 at 9:38 AM, thanked the LPN for the updates.</p> <p>On 4/12/18 at 5:35 PM, the ADON stated the facility called the NP when Resident #8 experienced signs and symptoms of a possible allergic reaction to the vancomycin. The ADON was unable to provide documentation the facility notified the ID physician who ordered the vancomycin, or if the NP contacted the ID physician when Resident #8 experienced signs and symptoms of an allergic reaction to the vancomycin on 2/20/18 or 3/2/18. The ADON stated she would expect there to be communication between the provider or the facility if the resident was experiencing an allergic</p>	F 684	<p>licensed staff in-serviced to updated Policy and Procedure.</p> <p>4. DNS / Designee will audit discontinued narcotics to ensure the updated Policy and Procedure is being followed. This will occur 3x/week for two weeks. Weekly for one month and PRN, thereafter.</p> <p>5. Date of compliance: 5/4/2018.</p>		

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F 684	<p>Continued From page 20</p> <p>reaction from a prescribed medication. The ADON stated she would expect staff to stop the medication promptly and call the prescribing physician and wait for further instructions.</p> <p>The facility failed to report the signs and symptoms of possible allergic reaction to the ID physician who had been ordering and monitoring the vancomycin. Resident #8 was transported to the hospital to treat a critically high level of potassium and a possible signs and symptoms of an allergic reaction to vancomycin.</p> <p>b. Resident #8's interventions were not implemented fully after possible allergic reaction occurred on 2/20/18 as follows:</p> <p>Resident #8's Physician orders documented Resident #8 was to receive 40 mg of prednisone for 5 days for rash and swelling, ordered 2/20/18 and completed 2/26/18.</p> <p>Resident #8's 2/20/18 through 2/26/18 MAR documented she was administered prednisone on 2/22/18 through 2/24/18. Resident #8 missed two doses of the prednisone on 2/21/18 and 2/25/18. The reason documented on 2/21/18 was documented as "absent from the facility." Resident #8 was to receive the prednisone at 7:00 AM in the morning, she was to receive 13 additional medications and/or treatments during that timeframe. The 2/21/18 MAR documented she received 2 of the 14 7:00 AM medications and/or treatments. The reason documented on 2/25/18 was "Resident Spit out." There was no documentation the NP was notified that Resident #8 did not receive two doses of her prednisone or that other attempts to administer the medication</p>	F 684			

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F 684	<p>Continued From page 21 were attempted.</p> <p>Resident #8's Physician orders documented Resident #8 was to receive 25 mg of Benadryl every 6 hours as needed for rash and swelling, ordered 2/20/18.</p> <p>Resident #8's 2/20/18 through 3/6/18 MAR documented she was administered Benadryl as needed on 3/2/18 and 3/5/18 for rash and itching.</p> <p>On 4/12/18 at 5:35 PM, the ADON stated she would look into why the medications were not given. The facility did not provide information prior to exit of the survey.</p> <p>2. Resident #3 was admitted to the facility on 2/5/18 with diagnoses which included brain cancer.</p> <p>An admission MDS assessment, dated 2/12/18, documented Resident #3 was cognitively intact and required extensive assistance of 1-2 staff members for cares.</p> <p>Resident #3's April 2018 Physician orders documented Resident #3 was to receive 1-gram (g) meropenem [antibiotic] every 8 hours for bacteremia (blood infection) for 10 days, ordered 4/9/18.</p> <p>Resident #3's 4/1/18 through 4/12/18 MAR documented Resident #3's meropenem was not administered on 4/11/18 at 6:00 AM. A Progress Note dated 4/11/18 at 10:48 AM, documented the reason for the missing dose was the medication was on order from the pharmacy.</p>	F 684			

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F 684	<p>Continued From page 22</p> <p>Resident #3's Pharmacy Delivery Records documented the facility received 3 doses of IV meropenem on 4/9/18, 4/10/18, and 4/11/18.</p> <p>On 4/12/18 at 2:03 PM, the ADON stated on 4/11/18 the facility was short staffed and had staff members call out sick. The ADON stated that she and three other nurses LPN #1, LPN #3, and LPN #4, covered the R-Hall medication cart on the morning of 4/11/18. The ADON stated the shift started with LPN #1 working the cart and the ADON relieved LPN #1. The ADON stated Resident #3's 6:00 AM meropenem dose was not administered and she did not know why, but was told the medication was not available. The ADON stated LPN #3 relieved her and then LPN #4 relieved LPN #3. The ADON stated Resident #3 received 2 of 3 doses of meropenem on 4/11/18 like the MAR documented. The ADON did not know if pharmacy delivered meropenem that morning or not.</p> <p>On 4/12/18 at 2:20 PM, the ADON was observed locating 3 IV bags of meropenem dated 4/12/18 with Resident #3's name on it. The ADON stated she did not open the refrigerator on 4/11/18 in the morning to check for the meropenem.</p> <p>On 4/12/18 at 2:30 PM, LPN #1 stated he could not locate Resident #3's IV meropenem in the refrigerator on 4/11/18 at 6:00 AM. He stated he called the physician and wait for further instructions. LPN #1 stated the physician did not call back on 4/11/18. LPN #1 stated the ADON and DNS instructed him to waited until the medication was located until providing the medication to the resident.</p>	F 684			

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F 684	<p>Continued From page 23</p> <p>On 4/12/18 at 2:33 PM, LPN #4 stated LPN #3 asked her to please administer Resident #3's 2:00 PM IV meropenem on 4/11/18. LPN #4 stated she located the IV meropenem in the refrigerator on 4/11/18, and she did not recall how many bags were in the refrigerator. LPN #4 stated she administered the 2:00 PM dose of meropenem.</p> <p>On 4/12/18 at 3:03 PM, LPN #3 stated on 4/11/18 around 2:00 PM, she located Resident #3's IV meropenem in the medication refrigerator and asked LPN #4 to please administer the medication. LPN #3 did not recall how many IV bags were in the refrigerator on 4/11/18. LPN #3 stated she did not recall pharmacy delivering any meropenem that morning or not. LPN #3 stated when she looked in the refrigerator the meropenem was there.</p> <p>On 4/12/18 at 6:25 PM, the DNS stated if an IV antibiotic dose was missed the nurse would call the physician for orders. The DNS stated if the physician added orders the nurse would call the pharmacy and the pharmacy would mix the medication and deliver the medication. The DNS stated he would expect the nurse to document the conversation.</p> <p>3. According to the Drug Enforcement Agency Disposal of Controlled Substances Act, dated 9/9/14, Long-Term Care Facilities (LTCF) are required to dispose of controlled substances "immediately," and no "longer than three business days after the discontinuation of use by the LTCF resident."</p> <p>The facility's Narcotic Destruction Policy, dated</p>	F 684			

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F 684	<p>Continued From page 24</p> <p>4/12/18, documented when a narcotic medication was "needing to be" wasted a witness would be present. The policy did not define when narcotics were to be disposed of. The policy was not signed off as reviewed by the medical director.</p> <p>Resident #9 was readmitted to the facility on 11/12/16 with diagnoses which included end stage liver disease.</p> <p>A quarterly MDS assessment, dated 3/26/18, documented Resident #9 was cognitively intact and exhibited no pain.</p> <p>Resident #9's November 2017 MAR included the order for Oxycodone 10 mg every four hours as needed for pain and that it was discontinued on 11/21/17. The November 2017 MAR did not include documentation that Resident #9 was administered Oxycodone.</p> <p>A physician's order, dated 11/21/17, documented Resident #9's Oxycodone 10 mg as needed was discontinued.</p> <p>Resident #9's narcotic count sheet, dated 11/14/17, documented 42 doses of Oxycodone 10 mg. The narcotic count sheet documented Staff #A signed that she administered 16 of 16 doses between 11/14/17 and 11/20/17, before the Oxycodone was discontinued on 11/21/17. After the Oxycodone was discontinued on 11/21/17, Staff #A continued to sign that she administered 15 of 15 doses between 11/22/17 to 11/26/17.</p> <p>Resident #9's narcotic count sheet for Oxycodone documented 11 doses remaining in the bubble pack card.</p>	F 684			

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F 684	Continued From page 25 An undated summary of the facility's investigation, signed by the Administrator, DNS, and ADON on 12/8/17, documented that on 11/27/17 it was reported to the DNS that during an attempt to waste a "discontinued narcotic," one of Resident #9's medication cards had, "medications taped back into the card." The DNS identified Staff #A was the only nurse signing the narcotic count sheet for Resident #9 and discovered the remaining 11 doses in the bubble pack card were Melatonin, not Oxycodone. The investigation summary documented that Staff #A was interviewed on 11/30/17 at 2:00 PM, at which time Staff #A admitted to taking Resident #9's Oxycodone and replaced the remaining 11 doses in the bubble pack card with Melatonin. The investigation documented Staff #A was taking the Oxycodone from Resident #9 for personal use since the beginning of November. Staff #A was suspended pending investigation. The facility began the destruction process 6 days after the Oxycodone was discontinued by the physician. 2. Resident #3 was admitted to the facility on 2/5/18 with diagnoses which included brain cancer. An admission MDS assessment, dated 2/12/18, documented Resident #3 was cognitively intact and required extensive assistance of 1-2 staff members for cares. Resident #3's April 2018 Physician orders documented Resident #3 was to receive 1 gram (g) meropenem [antibiotic] every 8 hours for bacteremia (blood infection) for 10 days, ordered	F 684			

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F 684	<p>Continued From page 26 4/9/18.</p> <p>Resident #3's 4/1/18 through 4/12/18 MAR documented Resident #3's meropenem was not administered on 4/11/18 at 6:00 AM. A Progress Note dated 4/11/18 at 10:48 AM, documented the reason for the missing dose was the medication was on order from the pharmacy.</p> <p>Resident #3's Pharmacy Delivery Records documented the facility received 3 doses of IV meropenem on 4/9/18, 4/10/18, and 4/11/18.</p> <p>On 4/12/18 at 2:03 PM, the ADON stated on 4/11/18 the facility was short staffed and had staff members call out sick. The ADON stated that she and three other nurses LPN #1, LPN #3, and LPN #4, covered the R-Hall medication cart on the morning of 4/11/18. The ADON stated the shift started with LPN #1 working the cart and the ADON relieved LPN #1. The ADON stated Resident #3's 6:00 AM meropenem dose was not administered and she did not know why, but was told the medication was not available. The ADON stated LPN #3 relieved her and then LPN #4 relieved LPN #3. The ADON stated Resident #3 received 2 of 3 doses of meropenem on 4/11/18 like the MAR documented. The ADON did not know if pharmacy delivered meropenem that morning or not.</p> <p>On 4/12/18 at 2:20 PM, the ADON was observed locating 3 IV bags of meropenem dated 4/12/18 with Resident #3's name on it. The ADON stated she did not open the refrigerator on 4/11/18 in the morning to check for the meropenem.</p> <p>On 4/12/18 at 2:30 PM, LPN #1 stated he could</p>	F 684			

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F 684	<p>Continued From page 27</p> <p>not locate Resident #3's IV meropenem in the refrigerator on 4/11/18 at 6:00 AM. He stated he called the physician and wait for further instructions. LPN #1 stated the physician did not call back on 4/11/18. LPN #1 stated the ADON and DNS instructed him to waited until the medication was located until providing the medication to the resident.</p> <p>On 4/12/18 at 2:33 PM, LPN #4 stated LPN #3 asked her to please administer Resident #3's 2:00 PM IV meropenem on 4/11/18. LPN #4 stated she located the IV meropenem in the refrigerator on 4/11/18, and she did not recall how many bags were in the refrigerator. LPN #4 stated she administered the 2:00 PM dose of meropenem.</p> <p>On 4/12/18 at 3:03 PM, LPN #3 stated on 4/11/18 around 2:00 PM, she located Resident #3's IV meropenem in the medication refrigerator and asked LPN #4 to please administer the medication. LPN #3 did not recall how many IV bags were in the refrigerator on 4/11/18. LPN #3 stated she did not recall pharmacy delivering any meropenem that morning or not. LPN #3 stated when she looked in the refrigerator the meropenem was there.</p> <p>On 4/12/18 at 6:25 PM, the DNS stated if an IV antibiotic dose was missed the nurse would call the physician for orders. The DNS stated if the physician added orders the nurse would call the pharmacy and the pharmacy would mix the medication and deliver the medication. The DNS stated he would expect the nurse to document the conversation.</p>	F 684			

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F 684	<p>Continued From page 28</p> <p>3. According to the Drug Enforcement Agency Disposal of Controlled Substances Act, dated 9/9/14, Long-Term Care Facilities (LTCF) are required to dispose of controlled substances "immediately," and no "longer than three business days after the discontinuation of use by the LTCF resident."</p> <p>The facility's Narcotic Destruction Policy, dated 4/12/18, documented when a narcotic medication was "needing to be" wasted a witness would be present. The policy did not define when narcotics were to be disposed of. The policy was not signed off as reviewed by the medical director.</p> <p>Resident #9 was readmitted to the facility on 11/12/16 with diagnoses which included end stage liver disease.</p> <p>A quarterly MDS assessment, dated 3/26/18, documented Resident #9 was cognitively intact and exhibited no pain.</p> <p>Resident #9's November 2017 MAR included the order for Oxycodone 10 mg every four hours as needed for pain and that it was discontinued on 11/21/17. The November 2017 MAR did not include documentation that Resident #9 was administered Oxycodone.</p> <p>A physician's order, dated 11/21/17, documented Resident #9's Oxycodone 10 mg as needed was discontinued.</p> <p>Resident #9's narcotic count sheet, dated 11/14/17, documented 42 doses of Oxycodone 10 mg. The narcotic count sheet documented Staff #A signed that she administered 16 of 16</p>	F 684			

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F 684	Continued From page 29 doses between 11/14/17 and 11/20/17, before the Oxycodone was discontinued on 11/21/17. After the Oxycodone was discontinued on 11/21/17, Staff #A continued to sign that she administered 15 of 15 doses between 11/22/17 to 11/26/17. Resident #9's narcotic count sheet for Oxycodone documented 11 doses remaining in the bubble pack card. An undated summary of the facility's investigation, signed by the Administrator, DNS, and ADON on 12/8/17, documented that on 11/27/17 it was reported to the DNS that during an attempt to waste a "discontinued narcotic," one of Resident #9's medication cards had, "medications taped back into the card." The DNS identified Staff #A was the only nurse signing the narcotic count sheet for Resident #9 and discovered the remaining 11 doses in the bubble pack card were Melatonin, not Oxycodone. The investigation summary documented that Staff #A was interviewed on 11/30/17 at 2:00 PM, at which time Staff #A admitted to taking Resident #9's Oxycodone and replaced the remaining 11 doses in the bubble pack card with Melatonin. The investigation documented Staff #A was taking the Oxycodone from Resident #9 for personal use since the beginning of November. Staff #A was suspended pending investigation. The facility began the destruction process 6 days after the Oxycodone was discontinued by the physician.	F 684			
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services	F 726			5/4/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135011	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/12/2018
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F 726	<p>Continued From page 30</p> <p>The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).</p> <p>§483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.</p> <p>§483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs.</p> <p>§483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, review of the Idaho Board of Nursing rules, and staff interview, it was determined the facility failed to ensure residents' care plans were developed and revised by licensed nurses. This was true for 3 of 9 sample residents (#1, #3, & #6) whose care plans were reviewed. The failure created the potential for</p>	F 726	<p>1. Corrective actions for affected residents include review and/or revision of Care Plans (created or revised by a C.N.A.) by a licensed nurse for appropriateness.</p> <p>2. All residents have the potential to be</p>		

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F 726	<p>Continued From page 31</p> <p>harm if the residents' needs and/or wishes were not competently and comprehensively addressed in their care plans. Findings include:</p> <p>The Idaho Board of Nursing rules at IDAPA (Idaho Administrative Procedures Act) 23.01.01.401, state one of the functions of a Registered Nurse is to develop and document a plan for nursing intervention based on assessment, analysis of data, identified nursing diagnoses and patient outcomes.</p> <p>The Idaho Board of Nursing rules at IDAPA 23.01.01.460, state one function of a Licensed Practical Nurse is to participate in the development and modification of the plan of care.</p> <p>The Idaho Board of Nursing rules at IDAPA 23.01.01.490, Unlicensed Assistive Personnel, documented, "The term unlicensed assistive personnel...is used to designate unlicensed personnel employed to perform nursing care services under the direction and supervision of licensed nurses..." and, "unlicensed assistive personnel may complement the licensed nurse in the performance of nursing functions, but may not substitute for the licensed nurse..."</p> <p>The rules do not allow Unlicensed Assistive Personnel to develop and document nursing care plans or make modifications to the plans.</p> <p>1. Resident #6 was admitted to the facility in 2016 and readmitted on 3/9/18 with multiple diagnoses, including metabolic encephalopathy, dementia, altered mental status, urinary tract infection, "severe" sepsis, neurogenic bladder, right below the knee amputation, diabetes</p>	F 726	<p>affected by the deficient practice. Corrective actions include having a licensed nurse review and revise all care plans to ensure appropriate care plans are consistent with patient needs.</p> <p>3. Systemic changes and measures provided are to continue our policy of initiating and/or updating plans of care with an interdisciplinary team approach. However a licensed nurse will be designated to open and initiate plans of care and interventions.</p> <p>4. DNS / Designee will audit the care planning process to ensure they are initiated and updated by a licensed nurse during our IDT care planning process. This will be done 3x/week for two weeks. Weekly for one month and PRN, thereafter.</p> <p>5. Date of Compliance: 5/4/2018</p>		

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F 726	<p>Continued From page 32</p> <p>mellitus, hypothyroidism, kidney disease, right eye blindness, and hypertension.</p> <p>All of Resident #6's care plan "Focus" areas, goals, and interventions/tasks dated 3/7/18, were documented as created, initiated, and revised by CNA #1. These care plans were for diabetes mellitus, oxygen therapy, hypertension, acute/chronic pain related to diabetic neuropathy, alteration in neurological status, kidney disease, hypothyroidism, the risk for delirium or confusion, the risk for impaired cognitive function or thought processes related to dementia, impaired visual function, ADL self care performance deficit, suprapubic catheter/neurogenic bladder, and the risk for falls.</p> <p>On 4/12/18 at 4:11 PM, LPN #3 identified herself as an MDS nurse and said that MDS assessments help staff develop care plans. The LPN said the IDT, including CNA #1, work on care plans. LPN #3 said a CNA cannot open and create care plans and that care plans "should be created by licensed professionals."</p> <p>2. Resident #3 was admitted to the facility on 2/5/18 with multiple diagnoses, including brain cancer, hemiplegia and hemiparesis following cerebral infarction (stroke), presence of a cerebrospinal fluid drainage device, and generalized muscle weakness.</p> <p>Resident #3's ADL self care performance deficit care plan, initiated 2/20/18, documented CNA #1 created and revised an intervention regarding the use a bedpan every 2 hours. The fall risk care plan, initiated 2/20/18, documented CNA #1 created 2 interventions and revised 1 intervention</p>	F 726			

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F 726	Continued From page 33 on the plan. On 4/12/18 at 6:25 PM, the DNS said CNA #1 "transcribes" during IDT care plan meetings and the nurse who signs the MDS is responsible for the care plan. 3. Resident #1 was admitted to the facility on 10/1/17 with multiple diagnoses, including quadriplegia and muscle weakness related to Guillain-Barre Syndrome. Resident #1's ADL self care performance deficit care plan, initiated 10/1/8, documented CNA #1 created 4 nursing rehab interventions. On 4/12/18 at 7:50 PM, the Administrator said the IDT, including CNA #1, develop and revise care plans. The Administrator said CNA #1 "might be scribing" for the IDT, but the CNA did not create care plans "in a vacuum."	F 726			
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.	F 755		5/4/18	

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F 755	Continued From page 34 §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observations, record review, facility policy review, and staff interviews, it was determined the facility failed to ensure prescription medications were available for administration to 1 of 9 residents (#8) whose medications were reviewed. This failure had the potential to compromise Resident #8's respiratory status and allow exacerbation of her gastroesophageal reflux disease. The facility also failed to ensure medications were secured and locked, including controlled medications. This was true for 8 of 8 bubble pack medication cards left unsecured on the counter at a nurses' station. This failure created the potential for residents, staff, and visitors to access medications not prescribed for them, including controlled medications. Findings include: 1. Resident #8 was admitted to the facility on	F 755	(#1) 1a. Corrective actions for affected residents include notifying Physician of missed medications. Resident has since discharged. 2a. All residents have the potential to be affected by the deficient practice. Corrective actions will include in-servicing all licensed staff to re-order medications in a timely manner to prevent any delays in providing medications to residents. Recommendation is to order medication seven (7) days before medication runs out, or as soon a possible.		

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F 755	<p>Continued From page 35 1/28/18 with diagnoses which included pancreatic cancer and staphylococcal arthritis (septic/infectious arthritis).</p> <p>An admission MDS assessment, dated 2/4/18, documented Resident #8 was cognitively intact and received IV antibiotics.</p> <p>a. Resident #8's physician orders documented she was to receive the following:</p> <ul style="list-style-type: none"> * 40 mg Protonix by mouth for Gastroesophageal reflux disease, ordered 2/7/18, * 1 inhalation orally of 18 microgram (mcg) dose of Spiriva every day for asthma, ordered 1/28/18 and discontinued 3/8/18, and * 1 inhalation orally of 100-50 mcg/dose Advair every 12 hours for asthma, ordered 1/28/18 and discontinued 3/8/18. <p>Resident #8's February 2018 MAR documented Resident #4 was not administered the medications and ointments ordered by the physicians as follows:</p> <ul style="list-style-type: none"> * Advair was not administered on 2/9/18 at 8:00 PM and on 2/13/18 and 2/14/18 at 8:00 AM and 8:00 PM. * Protonix was not administered on 2/26/18 at 7:00 AM. * Spiriva was not administered on 2/26/18 at 7:00 AM. <p>A Progress Note, dated 2/9/18 at 10:34 PM, documented Resident #8's Advair was on order from the pharmacy.</p> <p>Two Progress Notes, dated 2/13/18 at 9:54 AM</p>	F 755	<p>3a. Systemic changes and measures include updating Policy and Procedures to include re-ordering medications in a timely manner to prevent any delays in providing medications to residents. Policy recommendation is to reorder medications when there is 7 days left of the medication to ensure timely delivery. All licensed nurses in-serviced to updated policy.</p> <p>4a. DNS / Designee will randomly audit the ordering of medications to ensure the updated policy and procedure is being followed 3x/week for two weeks. Weekly for one month, then monthly and PRN, thereafter.</p> <p>5. Date of compliance: 5/4/2018</p> <p>_____</p> <p>(#2)</p> <p>1b. There were no specific residents identified as being affected. The medications identified with the deficient practice were promptly given to the assigned nurse who then placed them in the designated areas in the medication cart.</p> <p>2b. All residents have the potential to be effected by the deficient practice. Corrective actions will include in-servicing licensed staff that when signing in medications the nurse that signed for the</p>		

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F 755	<p>Continued From page 36</p> <p>and 9:47 PM, documented Resident #8's Advair was ordered from the pharmacy during the morning shift and it had not arrived. The notes documented the physician had not provided further instructions.</p> <p>Two Progress Notes, dated 2/14/18 at 8:09 AM and 9:24 PM, documented the facility was waiting for Resident #8's Advair to arrive from pharmacy. The notes documented the physician had not provided further instructions.</p> <p>A Progress Note, dated 2/26/18 at 8:17 AM, documented Resident #8's Protonix was not found in the medication cart and the pharmacy and physician were notified.</p> <p>A Progress Note, dated 2/26/18 at 8:17 AM, documented Resident #8's Spiriva was not found in the medication cart and the pharmacy and physician were notified.</p> <p>On 4/12/18 at 5:35 PM, the ADON stated she would look into why the medications were not given. The facility did not provide information prior to exit of the survey.</p> <p>b. Inconsistent ordering and delivering of medications:</p> <p>On 4/12/18 at 2:03 PM, the ADON stated the facility did not have written policy and procedures for ordering and receiving of medications. The ADON stated the process for delivering medications was the pharmacy delivered medications to the "A/B" nurses' station and the nurses from the other respective nurses' stations were called to collect the medications that</p>	F 755	<p>meds will ensure they are delivered to their designated areas.</p> <p>3b. Systemic changes and measures include updating policy and procedures to include the staff member signing in medications will be responsible to ensure they are delivered to their assigned areas and placed in the designated areas.</p> <p>4b. DNS / Designee will randomly audit the delivery and storage of medications to ensure the updated policy and procedure is followed. This will be done 3x/week for two weeks. Weekly for 1 month and monthly and PRN, thereafter.</p> <p>5b. Date of compliance: 5/4/2018</p>		

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F 755	<p>Continued From page 37</p> <p>belonged in their carts. The ADON stated if time allowed, the A/B nurse delivered the medications to the other nursing stations if the other nurses did not have time to pick them up at the A/B nursing station. The ADON stated if nurses at the other nursing stations did not have time to collect or deliver the medication, then the A/B nurse locked the medications in the A/B drug room until time allowed for delivery or collection. The ADON stated sometimes the pharmacy delivered the medications to the different nursing stations if they had time.</p> <p>On 4/12/18 at 2:20 PM, the ADON and surveyor arrived at the R-Hall nurses' station and observed a stack of eight medication bubble packs including 1 controlled medication sitting unattended on the counter. The ADON obtained the medication packs from the counter and called the nurse over her head-set to the nurses' station. On 4/11/18 at 2:23 PM, LPN #1 arrived at the nurses' station and the ADON handed him the stack of medication bubble packs to store in the medication cart. While the ADON handed the nurse the medication bubble packs she told the nurse not leave the medications unattended.</p> <p>On 4/12/18 at 2:25 PM, the ADON stated the medications should not have been delivered to the R-Hall nurses' station as they were. The ADON stated the nurse who delivered the medications should have "hand delivered" them "directly" to the nurse who should have put them in the medication cart. The ADON stated the delivering nurse should not have left the medications on the counter when LPN #1 was not available, as "it appears" to have happened. The ADON stated the medications should not</p>	F 755			

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

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F 755	<p>Continued From page 38 have been left unattended.</p> <p>On 4/12/18 at 2:33 PM, LPN #1 stated the medications found on the counter included eight bubble packs, including one controlled medication. LPN #1 stated he "normally" received a phone call when pharmacy delivered medications to the A/B-Hall nurses' station, and he would retrieve the medications. LPN #1 stated he did not receive a phone call 4/12/18 and did not know the medications were delivered to the R-Hall nurses' station. LPN #1 stated the pharmacy did not deliver the medication in a timely manner and some residents missed doses of medications. LPN #1 stated a few months ago it would take 2-3 days for medications to be ordered and delivered to the facility. LPN #1 stated the timeline for deliveries now was 6-7 days after the orders were placed. LPN #1 stated there was not a written process to assist nurses with ordering medications and when to order medications. LPN #1 stated he was unsure why there was a change in the turn around of the medication deliveries from the pharmacy.</p> <p>On 4/12/18 at 6:25 PM, the DNS stated when a medication was low, "a couple days left," and needed ordered, there were stickers on the back of the medication bubble pack cards that were faxed to pharmacy. The DNS stated when a nurse noticed a medication beginning to dwindle down they ordered the medication. The DNS said any nurse could order medications and the responsibility was not designated to a specific shift. The DNS stated if a medication was needed immediately, nurses could call the pharmacy for emergent needs.</p>	F 755			

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F 755	Continued From page 39 On 4/12/18 at 7:51 PM, the Administrator stated the medication delivery system in place could use improvement. The Administrator was unaware the facility did not have a written policy and procedure for medication ordering and delivery. The pharmacy services policy and procedure was requested from the Administrator at this time. This policy was not provided for review.	F 755			
F 835 SS=F	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and review of personnel files, a police report, and facility investigations, it was determined facility administration allowed a staff member, who was suspended from the facility for diversion of narcotics, to return to work when the administration had knowledge the staff member had misappropriated a resident's medication. This was true for 1 of 2 employees (Staff #A) whose personnel files were reviewed. The failure directly impacted 1 of 7 (#9) sample residents residing in the facility and placed the other 74 residents residing in the facility at risk of misappropriation of medications. Findings include: Resident #9 was admitted to the facility on 11/12/16 with multiple diagnoses, including end	F 835	1. No residents identified to be affected by the deficient practice after Staff member A had returned to work in a non-nursing capacity with no access to medications. Corrective actions were that Staff member A was asked to not return to facility until a final determination of her future can be made in coordination with her Program for recovering Nurses and the Idaho State Board of Nursing. 2. All residents have the potential to be affected by the deficient practice. Corrective actions will include: Not allowing staff who have know to have history of misappropriation of medications, to work in any form without first closely collaboration and	5/4/18	

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F 835	<p>Continued From page 40 stage liver disease.</p> <p>A Physician's order for Resident #9, dated 1/25/17, documented Oxycodone 10 mg every four hours as needed for pain.</p> <p>A Physician's verbal order, dated 11/21/17, documented Resident #9's Oxycodone 10 mg every four hours as needed for pain was discontinued.</p> <p>Resident #9's narcotic count sheet, dated 11/14/17, documented 42 doses of Oxycodone 10 mg. The narcotic count sheet documented Staff #A signed that she administered 16 of 16 doses between 11/14/17 and 11/20/17, before the Oxycodone was discontinued on 11/21/17. After the Oxycodone was discontinued on 11/21/17, Staff #A continued to sign that she administered 15 of 15 doses between 11/22/17 to 11/26/17.</p> <p>Resident #9's narcotic count sheet for Oxycodone documented 11 doses remaining in the bubble pack card.</p> <p>An undated summary of the facility's investigation, signed by the Administrator, DNS, and ADON on 12/8/17, documented that on 11/27/17 it was reported to the DNS that during an attempt to dispose of a "discontinued narcotic," one of Resident #9's medication cards had "medications taped back into the card." The DNS identified Staff #A as the only nurse signing the narcotic count sheet for Resident #9 and discovered the remaining 11 doses in the bubble pack card were Melatonin, not Oxycodone.</p> <p>The investigation summary documented that</p>	F 835	<p>documenting approvals through a program for recovering nurses and the Idaho State Board of Nursing.</p> <p>3. Systemic changes and measures taken include closely coordinating with a chosen program for recovering nurses and Idaho State Board of Nursing for approval to work in a closely monitored environment set forth by these two entities.</p> <p>4. Administrator / designee will monitor any instance of employees involved in the misappropriation of medication to ensure not allowing said staff to work in any form without first correlating and documenting efforts/approvals through a chosen program for recovering nurses and the Idaho State Board of Nursing in a closely monitored environment as set forth by these two entities for 3x/week for two weeks. Weekly for 1 month and PRN, thereafter.</p> <p>5. Date of compliance: 5/4/2018</p>	

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135011	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/12/2018
NAME OF PROVIDER OR SUPPLIER GATEWAY TRANSITIONAL CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 527 MEMORIAL DRIVE POCATELLO, ID 83201		
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F 835	<p>Continued From page 41</p> <p>Staff #A was interviewed on 11/30/17 at 2:00 PM, at which time Staff #A admitted to taking Resident #9's Oxycodone and replaced the remaining 11 doses in the bubble pack card with Melatonin. The investigation documented Staff #A was taking the Oxycodone from Resident #9 for personal use since the beginning of November. Staff #A was suspended pending investigation. On 4/11/18 at 1:00 PM, the facility provided a current employee job profile that listed Staff #A as an LPN.</p> <p>The investigation summary documented the police department was notified on 12/1/17, four days after the misappropriation of Resident #9's controlled medication by Staff #A was reported to the DNS on 11/27/17.</p> <p>On 4/16/18, the facility provided a Police Department Detail Incident Report, dated 12/1/17. The report documented a police officer responded to the facility regarding a reported theft of medication. The police report documented a police officer spoke to Staff #A on 12/2/17 and Staff #A, "...admitted to taking the pills between 11/14/17 and 11/17/17...she had taken at least eleven Oxycodone pills, possible [sic] more, though she did not remember the exact amount...she had taken the pills for personal use, and had already consumed them." The report documented the incident was forwarded to the narcotics division. The police report documented on 12/21/17 the narcotics division was not mandated to press a charge for the "theft" of the Oxycodone.</p> <p>On 4/11/18 at 4:25 PM, the DNS stated Staff #A told him that she was in a program for recovering</p>	F 835			

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F 835	<p>Continued From page 42</p> <p>nurses. The DNS was unable to provide documentation about the recovering nurses' program and was unaware of any restrictions or limitations for Staff #A. The DNS stated Staff #A was not working as a nurse, was not providing direct patient care, did not have access to the electronic medication records, and did not have keys to access the medication carts or medication rooms. The DNS stated Staff #A returned to work in February under his supervision and her job duties were filing paperwork.</p> <p>Staff #A's employee time record documented Staff #A returned to work 2/12/18 through 4/9/18 and worked 4-5 days per week.</p> <p>On 4/12/18 at 10:00 AM, the DNS stated Staff #A filed paperwork in his office or in the charge nurse room within the conference room when he was in the building. The DNS provided a Program For Recovering Nurses (PRN) contract for Staff #A dated 1/7/18. Staff #A signed the contract on 1/7/18 and the witness signed the contract five days later on 1/12/18. The DNS stated he did not have the PRN contract until 4/12/18 and he was unaware that written approval from the PRN program was required for Staff #A to return to work in any capacity.</p> <p>The PRN contract signed by Staff #A documented, "I shall not return to work until I receive written approval from the PRN and support of my treatment provider. In the event that I change positions or seek new employment, I shall obtain approval from the PRN at least two weeks prior to accepting the position. To begin working, I must first have a work monitor in place</p>	F 835			

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F 835	<p>Continued From page 43 and all releases must be signed for the hiring facility."</p> <p>On 4/12/18 at 10:30 AM, the DNS stated he was unaware Staff #A had worked 3 of 5 Saturdays in March 2018 (3/17/18, 3/24/18, and 3/31/18). The DNS stated he was not in the facility and Staff #A was not supervised on those dates.</p> <p>The untitled facility's investigation, dated 12/8/17, documented the results of the investigation determined, "we feel this was an isolated incident that began in the beginning of November, involved one resident, and did not result in bodily harm or any adverse effect to the identified resident or other residents. The identified nurse was suspended, reported to the nursing board, and police were notified." The investigation was signed by the Administrator, DNS, and ADON.</p> <p>On 4/11/18 at 4:25 PM, the DNS stated Staff #A told him that she was in a rehab program for recovering nurses. The DNS did not recall the exact date and had no documentation when Staff #A shared this information with him. The DNS stated Staff #A returned to work on 2/12/18 to file paperwork only and was not providing direct patient care, did not have access to the electronic medication records, and did not have keys to access the medication carts or medication rooms. The DNS was unable to provide documentation of communication with the PRN program.</p> <p>The facility's current employee job profile documented Staff #A was listed as Licensed Practical Nurse. Staff #A's employee time records documented Staff #A returned to work on</p>	F 835			

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F 835	<p>Continued From page 44 2/12/18.</p> <p>On 4/12/18 at 8:45 AM, the DNS stated he called the rehab program on 4/11/18 and received a copy of the recovering nursing program for Staff #A. The DNS provided a job description for Staff #A, dated 4/12/18, documented, "Staff #A will do mostly clerical duties including but not limited to, filing paperwork for the director of nurses the assistant director of nurses, ward clerk, medical records and Human Resources. Staff #A will continue with these job descriptions/restrictions until further documentation can be verified that Staff #A has been approved and is improving with her monitoring program for the program of recovery nurses and the Idaho State Board of Nursing." The untitled document was signed by the Administrator and the DNS. The DNS stated Staff #A had not reviewed or signed the job description.</p> <p>On 4/12/18 at 10:00 AM, the DNS stated Staff #A verbally told the DNS she was in PRN program and she returned to work on 2/12/18, filing paperwork with under direct supervision with the ADON or DNS in the their office. The DNS stated he did not receive documentation or have communication from the recovering nursing program. The DNS provided a contract from the PRN program that he received on 4/12/18.</p> <p>On 4/12/18 at 7:50 PM, the Administrator stated the DNS notified the Board of Nursing via phone on 12/1/17 regarding the misappropriation of Resident #9's Oxycodone by Staff #A. The Administrator was unable to provide documentation the Board of Nursing was notified. The Administrator was not aware Staff #A was</p>	F 835			

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F 835	<p>Continued From page 45</p> <p>working in the facility unsupervised on 3/17/18, 3/24/18, and 3/31/18. The Administrator was unable to provide documentation of communication with the PRN program regarding Staff #A. The Administrator stated the investigation was completed under the direction of their corporation and he thought it was complete. The Administrator stated the investigation could use some improvement looking back on it now.</p> <p>2. Also refer to:</p> <ul style="list-style-type: none"> * F602 as it relates to the facility's failure to ensure residents were free from misappropriation of a controlled medication. * F608 as it relates to the facility's failure to ensure the facility reported misappropriation of medications to law enforcement within 24 hours. * F609 as it relates to the facility's failure to ensure the facility failed to report the misappropriation of medications to the State Survey Agency within 24 hours. 	F 835			



IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
DEBBY RANSOM, R.N., R.H.I.T – Chief
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January 8, 2019

Tory Bosworth, Administrator
Gateway Transitional Care Center
527 Memorial Drive
Pocatello, ID 83201-4063

Provider #: 135011

Dear Mr. Bosworth:

On **April 11, 2018** through **April 12, 2018**, an unannounced on-site complaint survey was conducted at Gateway Transitional Care Center.

Observations for quality of care, including wound care and diabetic management, were made for eight individual residents. Licensed nurses were observed while they provided wound care and/or skin treatments for two of the residents and blood glucose level checks were observed for two of the residents. Certified Nursing Assistants were also observed as they provided direct patient care for several residents.

The clinical records of nine residents, including the closed record for a resident who had been discharged, were reviewed for Quality of Care issues. The facility's Grievance files were reviewed, as were Incident and Accident Reports, facility reported incidents, and investigations of allegations of abuse and neglect.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007716

ALLEGATION #1:

A two inch pressure ulcer on the heel was found on Christmas Eve when a resident was out of the facility during the Christmas holiday. The resident returned to the facility on Christmas Day and the charge nurse was told about the ulcer. The charge nurse was not aware of the wound but said she would check it. The following day the nurses still had not checked the wound and now the resident has a cellulitis above the wound and is attending a wound clinic for treatment. The nursing staff were not conducting regular skin checks.

FINDINGS #1:

Four residents, two resident representatives, three licensed nurses, including the Director of Wound Care, several Certified Nursing Assistants, the Director of Nursing, the Assistant Director of Nursing, and the Administrator were interviewed regarding various quality of care issues, including pressure ulcers, wounds, and diabetic management.

A resident's clinical record documented skin assessments were conducted weekly and there were no heel skin issues prior to the resident leaving the facility on December 24, 2017. The record documented a right heel ulcer was reported to facility staff when the resident returned to the facility at 7 p.m. on December 25, 2017 and heel medix boots were implemented right away. The ulcer was assessed as a diabetic foot ulcer and treatment was started timely. Four days later, on December 29, 2017, redness, warmth, and edema to the right foot and lower leg was noted and the resident was assessed by a wound care physician the same day. There was documented evidence the facility regularly assessed, monitored, and followed physician treatment orders regarding the right heel ulcer.

Based on the observations, record reviews, and interviews, it was determined the allegation could not be substantiated due to lack of sufficient evidence.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

On January 10, 2018, a deep laceration on the underside of a resident's penis, from meatus to the base of the shaft, was found and the facility nursing staff were not aware of the laceration.

FINDINGS #2:

A resident's clinical record documented and interviews with two licensed nurses, including the Director of Wound Care, the Director and Assistant Directors of Nursing, and an interested party, confirmed that a tear to the head of the resident's penis was found when a visitor assisted the resident to use the toilet. The clinical record documented a "small" tear at the "head of his meatus" with a "small" amount of blood and a "larger tear but no blood" at the "backside" of the penis was identified at the same time. The Director of Wound Care said she assessed the penis and the tear at the head of penis was more like "trauma" and the larger tear at the posterior aspect was an old injury that was well healed and about four inches in length. The resident's clinical record documented weekly skin assessments were conducted as care planned and no injuries to the penis were identified prior to January 10, 2018.

Based on the interviews, observations, and record reviews, the allegation could not be substantiated due to a lack of sufficient evidence.

Tory Bosworth, Administrator
January 8, 2019
Page 3 of 3

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

On the morning of January 10, 2018, while at a wound clinic appointment, a resident's blood glucose (BG) level was in the 60s and the resident was disoriented and seeing something that was not there, after orange juice and glucose tablets had already been provided.

FINDINGS #3:

The clinical record documented a resident reported feeling "low" and requested a BG check at 3:30 a.m. on January 10, 2018. The clinical record documented the BG was "67," orange juice was administered, and by 3:50 a.m., the BG was 112 and the resident reported feeling better.

Based on observations, interviews, and record review, the facility provided timely assessment and intervention regarding the resident's low BG level. Deficient practice was not identified and therefore, the allegation was not 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. If you have any questions, comments or concerns regarding this matter, please contact Laura Thompson, RN, or Belinda Day, RN, Supervisors, Long Term Care Program at (208) 334-6626, Option #2.

Sincerely,



Belinda Day, RN, Supervisor
Long Term Care Program

BD/lj



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HEALTH & WELFARE

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June 20, 2019

Tory Bosworth, Administrator
Gateway Transitional Care Center
527 Memorial Drive,
Pocatello, ID 83201-4063

Provider #: 135011

Dear Mr. Bosworth:

On **April 12, 2018**, an unannounced on-site complaint survey was conducted at Gateway Transitional Care Center. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007769

ALLEGATION #1:

Residents were missing doses of medications and the medications were not being provided in a timely manner from the pharmacy for administration.

FINDINGS #1:

An unannounced on-site complaint survey was conducted from April 11, 2018 through April 12, 2018.

Nine residents were observed for Quality of Care issues, medication management, and pharmacy concerns. Quality of Care practices were observed, including staff interaction with residents, medication administration, and delivery.

Tory Bosworth, Administrator
June 20, 2019
Page 2

The records of nine residents were reviewed for Quality of Care issues and medication management. The facility's grievance file was reviewed, as well as its medication error reviews, abuse investigations, and reportable incidents. Six residents and three nurses were also interviewed regarding various Quality of Life and Care issues. The Director of Nursing and the Administrator were interviewed regarding medication ordering systems, .

The record of one resident was reviewed and documented multiple medications were unavailable for administration. The resident did not receive their inhaled medication Advair, Protonix (decreases acid in the stomach), and another inhaled medication Spiriva. Progress notes documented the medication was not sent by the pharmacy for administration.

CONCLUSIONS:

Based on record review and resident and staff interview, it was determined the allegation was substantiated and cited at F755 related to the facility's failure to ensure medications were available for administration and medications were stored in a secure manner.

ALLEGATION #2:

A resident did not receive medications as ordered.

FINDINGS #2:

Nine resident records were reviewed for medication management and administration, pharmacy delivery orders were reviewed, and staff were interviewed.

One resident had a physician order for an antibiotic to be administered intravenously every 8 hours for a blood infection for 10 days.

The resident's medication administration record documented the antibiotic was not administered as ordered for one day, they received 2 out of 3 doses ordered. A Progress Note documented the reason for the missing dose was the medication was on order from the pharmacy.

The Pharmacy Delivery Records documented the facility received 3 doses of the antibiotic on three separate days.

The Assistant Director of Nursing (ADON) stated the morning dose was not administered and she did not know why, but was told the medication was not available. The ADON did not know if pharmacy delivered the medication that morning or not. The ADON stated she did not check the refrigerator in the morning to check for the antibiotic.

The Director of Nursing stated if an antibiotic dose was missed the nurse called the physician for orders. The Director of Nursing stated if the physician added orders the nurse called the pharmacy and the pharmacy mixed the medication and then delivered it. The Director of Nursing stated he expected the nurse to document the conversation.

CONCLUSIONS:

Based on the results of the investigation, the allegation was substantiated. A deficiency was cited at F684 as it related to the failure of the facility to ensure medications and treatments were provided to a resident per physician orders.

ALLEGATION #3:

Residents' tube feedings were not administered as ordered.

FINDINGS #3:

Two resident records were reviewed for management and administration of tube feedings, residents and staff were interviewed.

Two resident records documented they received their tube feedings as ordered on the Medication Administration Records. Both residents were interviewed and stated they received their tube feedings as ordered by their physician.

CONCLUSIONS:

Based on the results of the investigation, the allegation could not be substantiated.

ALLEGATION #4:

A resident's medications were taken by a staff member.

FINDINGS #4:

Nine resident records were reviewed, residents were interviewed, and staff were interviewed.

A resident's record documented he had a discontinued order for an as needed pain medication. The resident's Medication Administration Record documented he was not administered the pain medications. The resident's narcotic sheets documented he was administered thirty doses of an as needed pain medication. The resident stated he did not request the pain medication and he did not experience frequent pain.

CONCLUSIONS:

Based on the results of the investigation, the allegation was substantiated. A deficiency was cited at F602 as it related to the failure of the facility to ensure staff did not take medications from residents. A deficiency was cited at F608 as it related to the failure of the facility to ensure staff reported the crime in a timely manner to the police. A deficiency was cited at F609 as it related to the failure of the facility to ensure staff reported the crime in a timely manner to the state agency.

ALLEGATION #5:

Resident care plans were not completed and specific for each resident.

FINDINGS #5:

Nine resident records were reviewed for care plan completeness and timeliness and staff were interviewed.

The care plans for three residents were missing documentation related to appropriate diabetic management. One resident's record had a care plan which documented the potential for nutritional problems related to diabetes. The care plan did not include further reference or interventions related to diabetes.

Another resident's care plan addressed diabetes mellitus and included signs and symptoms of low blood sugar and high blood sugar, but the care plan did not include instructions for staff on how to treat these events.

CONCLUSIONS:

Based on the results of the investigation, the allegation was substantiated. A deficiency was cited at F655 and F656 as it related to the failure of the facility to ensure care plans were specific and complete for each resident.

ALLEGATION #6:

Residents were being left in wet incontinent briefs for extended periods of time.

FINDINGS #6:

Four resident records were reviewed for incontinence management, Resident Council meeting minutes were reviewed, observations were conducted, and residents were interviewed.

Tory Bosworth, Administrator
June 20, 2019
Page 5

The four residents had incontinence care plans in place and their medical records did not include documentation there were concerns they were left in wet briefs for extended periods of time. Resident Council meeting minutes from November 2017 to March 2018 did not document concerns with incontinence care.

Residents were observed for incontinence care by staff and their briefs were not left wet for extended periods of time. CNAs were observed checking and changing the residents' briefs according to their needs and their care plans.

One of the four residents said they were incontinent and said staff checked their brief regularly and there were no concerns regarding incontinence care by staff. CNAs and nurses said residents were not left wet for extended periods of time and said if they found that they would report it to their supervisors.

CONCLUSIONS:

Based on investigative findings, the allegation was could not be substantiated.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

Thank you for the courtesies and assistance extended to us during our visit. 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 any questions, comments or concerns regarding this matter, please contact Laura Thompson, RN, or Belinda Day, RN, Supervisors, Long Term Care Program at (208) 334-6626, Option #2.

Sincerely,



LAURA THOMPSON, RN, Supervisor
Long Term Care Program

LT/slj