



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RUSS BARRON – Director

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

August 17, 2018

Briar Heisler, Administrator
Life Care Center Of Idaho Falls
2725 East 17th Street
Idaho Falls, ID 83406-6601

Provider #: 135091

Dear Ms. Heisler:

On **August 8, 2018**, a survey was conducted at Life Care Center Of Idaho Falls by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be an isolated deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567 listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct." **Please provide ONLY ONE completion date for each federal and state tag (if applicable) in column (X5) Completion Date** to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **August 27, 2018**. Failure to submit an acceptable PoC by **August 27, 2018**, may result in the imposition of penalties by **September 19, 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 will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **September 12, 2018 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **November 6, 2018**. A change in the seriousness of the deficiencies on **September 22, 2018**,

Briar Heisler, Administrator
August 17, 2018
Page 3

may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **November 8, 2018** includes the following:

Denial of payment for new admissions effective **November 8, 2018**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying non-compliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **February 8, 2019**, if substantial compliance is not achieved by that time.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, CMS will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact 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 **November 8, 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:

Briar Heisler, Administrator
August 17, 2018
Page 4

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

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

- BFS Letters (06/30/11)

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

This request must be received by **August 27, 2018**. If your request for informal dispute resolution is received after **August 27, 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/

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135091	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/08/2018
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF IDAHO FALLS			STREET ADDRESS, CITY, STATE, ZIP CODE 2725 EAST 17TH STREET IDAHO FALLS, ID 83406		
(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 a complaint survey conducted at the facility from August 6, 2018 to August 8, 2018. The surveyors conducting the survey were: Brad Perry, LSW, Team Coordinator Arnold Rosling , RN Survey Abbreviations: CNA = Certified Nursing Assistant DON = Director of Nursing LPN = Licensed Practical Nurse MDS = Minimum Data Set	F 000			
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interviews, it was determined the facility failed to ensure 1 of 1 resident (Resident #4) reviewed for self-administration was safe to self-administer inhalation therapy medication without supervision. This deficient practice had the potential to reduce the effectiveness of Resident #4's inhalation therapy medication. Findings include: The Diagnosis Section of the electronic medical record stated Resident #4 was admitted to the facility on 7/5/18 with a primary diagnosis of	F 554	Preparation and/or execution of the plan of correction does not constitute admission or agreement by the provider of the truth of the facts or conclusions set forth in the statement of deficiencies. Specific Resident: Resident #4 has had medication self-administration review completed associated with being left unsupervised while receiving nebulizer treatment. LPN #1 educated on requirements to be completed prior to leaving a resident unsupervised during	9/12/18	

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

TITLE

(X6) DATE

Electronically Signed

08/24/2018

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135091	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/08/2018
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF IDAHO FALLS			STREET ADDRESS, CITY, STATE, ZIP CODE 2725 EAST 17TH STREET IDAHO FALLS, ID 83406		
(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 554	<p>Continued From page 1</p> <p>multiple sclerosis and additional diagnoses of quadriplegia (paralysis of all four limbs) and pneumonia.</p> <p>The Physician Orders, dated 7/5/18, documented Resident #4 was to receive DuoNeb 2.5 milligrams nebulizer (a sterile inhalation solution containing a combination of medication used to increase airflow to the lungs) three times a day and as needed every 6 hours.</p> <p>During an observation on 8/6/18 at 4:05 PM, Resident #4 was receiving a nebulizer inhalation therapy being administered through a mask. The mask was observed on the resident's face, and it was observed to slowly fall below the resident's chin during the 10 minutes the inhalation therapy was observed. At 4:15 PM, LPN #1 came into the room, looked at the chamber and informed Resident #4 there was still some fluid left. LPN #1 then adjusted the mask and left the room. LPN #1 returned to the room at 4:19 PM and stopped the treatment. The mask during the 4 minute interval started to slide down his nose and chin again.</p> <p>Resident #4's medical record, reviewed on 8/7/18, did not include documentation he was evaluated to self-administer medications.</p> <p>On 8/7/18 at 12:15 PM, LPN #1 and the DON were interviewed about Resident #4's ability to self-administer medications. LPN #1 was not aware she had to stay with Resident #4 during administration of the nebulizer treatment. The DON indicated the resident was not a candidate for self-administration of medication due to the diagnosis of quadriplegia.</p>	F 554	<p>inhalation treatment.</p> <p>Other Residents: Facility residents who receive inhalation medications will have medication self-administration review completed prior to being left unsupervised during inhalation medication delivery.</p> <p>Systemic Change: 1) Facility wide audit completed to assess all residents receiving inhalation medications. 2) Clinical assessment completed of facility residents receiving inhalation medication with completion of self-administration review if indicated to be left unsupervised during inhalation medication delivery. 3) Disclaimer added to facility residents' medication administration record and/or treatment administrative record receiving inhalation medication therapy stating: A medication self-administration review form must be completed and determined clinically appropriate prior to leaving the resident unsupervised during treatment. 4) Facility Licensed Nursing (LN) staff educated on completion of medication self-administration review and determined clinically appropriate prior to leaving a resident unsupervised during the delivery time of inhalation medication.</p> <p>Monitoring: Nurse Manager and/or designee to audit residents being left unsupervised during inhalation medication delivery for completion of medication self-administration review form and determined clinically appropriate. 2 X week for 4 weeks.</p>		

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

PRINTED: 02/08/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135091	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/08/2018
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF IDAHO FALLS			STREET ADDRESS, CITY, STATE, ZIP CODE 2725 EAST 17TH STREET IDAHO FALLS, ID 83406		
(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 554	Continued From page 2	F 554			
F 656 SS=D	<p>Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)</p> <p>§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 -</p> <p>(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</p> <p>(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).</p> <p>(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.</p> <p>(iv) In consultation with the resident and the resident's representative(s)-</p> <p>(A) The resident's goals for admission and desired outcomes.</p> <p>(B) The resident's preference and potential for</p>	F 656	<p>Weekly for 8 weeks. Results of audit will be reviewed at QAPI for trending and ongoing education and compliance.</p>	9/12/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135091	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/08/2018
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF IDAHO FALLS			STREET ADDRESS, CITY, STATE, ZIP CODE 2725 EAST 17TH STREET IDAHO FALLS, ID 83406		
(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 656	<p>Continued From page 3</p> <p>future discharge. Facilities must document whether the resident's desire to return to the 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 ensure 1 of 6 (Resident #4) residents whose care plans were reviewed, addressed the resident's hydration needs. This failure placed Resident #4 at risk of dehydration and subsequent health decline. Findings include:</p> <p>The Diagnosis Section of the electronic medical record documented Resident #4 was admitted to the facility on 7/5/18, with a primary diagnosis of multiple sclerosis and additional diagnoses of quadriplegia (paralysis of all four limbs) and pneumonia.</p> <p>The admission MDS assessment (a comprehensive resident assessment) completed 7/12/18, identified a trigger to complete further assessment in the area of dehydration. The Care Area Assessment (CAA) completed 7/18/18 at 11:31 AM, by the Acting MDS Coordinator indicated a care plan would be initiated for a hydration/dehydration problem.</p> <p>The IDT meeting note, dated 7/13/18, identified the care plan meeting was held prior to completion of the CAA. The IDT meeting note</p>	F 656	<p>Specific Resident: Resident #4's care plan reviewed and corrected to include Resident's hydration needs.</p> <p>Other Resident: Facility residents who trigger on their comprehensive assessment for hydration will have an associated plan of care addressing their hydration needs unless not clinically indicated with rationale listed on their care area trigger (CAA) worksheet.</p> <p>Systemic Changes: 1) Facility wide audit completed on most recent comprehensive assessments to determine residents who triggered a CAA hydration. 2) Plan of care reviews completed for residents who triggered a CAA in hydration to include hydration needs if resident was not indicated to have a plan of care CAA worksheet reviewed for clinical rational. 3) Education provided to LN staff on plan of care development including hydration needs if indicated. 4) Minimum Data Set (MDS) Nurse to review residents who trigger a CAA in hydration for plan of care needs. MDS Nurse will complete plan of</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135091	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/08/2018
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF IDAHO FALLS			STREET ADDRESS, CITY, STATE, ZIP CODE 2725 EAST 17TH STREET IDAHO FALLS, ID 83406		
(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 656	<p>Continued From page 4</p> <p>identified Resident #4 was receiving thickened liquids. The meeting notes did not identify hydration/dehydration as a potential problem.</p> <p>The facility used both paper and electronic medical records. There were two care plans for Resident #4. The electronic care plan copy was dated 7/5/18 and had no updates. The paper care plan copy was dated 7/7/18 and had no updates. Both care plans were reviewed on 8/8/18 and neither document contained information about the residents' hydration/dehydration needs.</p> <p>The MDS Coordinator was interviewed on 8/8/18 at 10:20 AM, about the medical record having two care plans and lack of the updates for Resident #4's hydration/dehydration needs. She responded that the Acting MDS Coordinator completed the MDS and CAA but did not finish the process. She stated the care plan would be updated. No further information was provided.</p>	F 656	<p>care and verify hydration needs are addressed or CAA worksheet includes clinical rationale why plan of care was not required with Nurse manager and/or LN.</p> <p>Monitoring: Nurse Manager and/or designee will audit residents who trigger CAA for hydration to verify hydration needs are identified on the plan of care or CAA worksheet includes clinical rationale why care plan development is not indicated. Weekly for 12 weeks. Results of audit will be reviewed at QAPI for trending and ongoing education and compliance.</p>		



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
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

April 10, 2019

Briar Rose Fenn, Administrator
Life Care Center of Idaho Falls
2725 East 17th Street
Idaho Falls, ID 83406-6601

Provider #: 135091

Dear Ms. Fenn:

On **August 6, 2018** through **August 8, 2018**, an unannounced on-site complaint survey was conducted at Life Care Center of Idaho Falls. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007888

ALLEGATION #1:

Nursing staff were abusive and retaliated against residents by giving them extra doses of laxatives which resulted in severe diarrhea.

FINDINGS #1:

During the investigation five residents were observed and six resident's records, which included a closed record, were reviewed for Quality of Care, abuse, and medication management. Multiple interviews were conducted with residents and family members. Multiple staff members were interviewed and observed regarding abuse and medication management. Facility abuse allegations, grievances, and Resident Council minutes were reviewed. Several nurses were observed during medication pass.

All six residents' records were reviewed for medication errors and three of the six residents' medication orders and Medication Administration records, including a resident admitted to the facility in March 2018, were reviewed for laxative medication administration. Bowel medications for all three residents were administered as ordered without extra doses of laxatives.

During the review of the records for one resident, admitted March 2018, physician orders and medication administration records documented the resident had received Senna and Colace for constipation and they were either given as ordered or were refused by the resident and not administered. The nurse progress notes and the medication record did not document that the resident had severe diarrhea. A physician progress note documented the resident and physician discussed bowel medication regimen and the resident decided to keep the current medications in place due to his/her fear of bowel impaction.

Several nurses and several residents were observed during medication pass and residents received the correct medications as ordered. Several facility staff, including an identified nurse, were observed to interact with residents in a respectful manner.

Several residents and two family members said staff were not abusive and they had no concerns regarding staff retaliation if they raised a concern or a complaint. Multiple staff said if they suspected or witnessed any form of abuse or retaliation, they would report it immediately. Two CNAs and three nurses who had worked with a resident admitted March 2018, said the resident did not have severe diarrhea and they did not witness any form of abuse towards the resident. One nurse said the resident complained of loose stools a few times and the nurse had offered an anti-diarrhea medication, but the resident refused because he/she did not want to be 'stopped up.' The Ombudsman said she had attended a care conference in July 2018 with the resident and family members and where several concerns were addressed and she noted that all those in attendance had walked away with a good plan in place to address the concerns.

The allegation was unsubstantiated due to lack of evidence of abuse and retaliation.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

Call lights were not answered for over an hour and staff would turn off call lights without addressing residents' needs.

FINDINGS #2:

During the investigation observations were conducted for call lights, Resident Council meeting minutes were reviewed, facility grievances were reviewed, and resident and family members were interviewed.

During observations of call light response times no concerns were identified. The call lights were answered within minutes and residents' needs were taken care of before call lights were turned off multiple times throughout the survey.

Resident Council Meeting minutes and Grievances from March to August 2018, documented that call light response times were not an issue.

Several residents and two family members said call lights were answered in a timely manner and residents' needs were met. Multiple CNAs and nurses said call lights were answered timely and they met residents' needs. The Director of Nursing and the Administrator said call lights were answered timely and residents' needs were met. The Ombudsman said she had observed call lights in the facility on different occasions after an allegation of long call light response times were reported and said call light response times had improved and were answered timely. The Ombudsman said when she interviewed multiple residents, they said call lights were answered timely.

The allegation was unsubstantiated due to lack of evidence of long call light response times.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

Residents were being left in wet incontinent briefs for over an hour.

FINDINGS #3:

Five out of six residents' records were reviewed for incontinence management, Resident Council meeting minutes were reviewed, observations were conducted, and residents were interviewed.

All five residents had incontinence care plans in place and their medical records did not document being left wet for extended periods of time. Resident Council meeting minutes from March to August 2018 did not document concerns with incontinence care.

During the survey, four residents were observed for incontinence and their briefs were not left wet for extended periods of time. Several CNAs were observed checking and changing the residents' briefs according to their needs and their care plans.

One of the four residents said he/she was incontinent and said staff checked his/her brief regularly and had no concerns regarding his/her incontinence care. Two family members of two of the four residents said residents' incontinence care was good and had not observed the residents being left wet for extended periods of time. Several 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. The Director of Nursing and the Administrator said residents were changed according to their needs and were not left wet for extended periods of time.

The allegation was unsubstantiated due to lack of evidence regarding residents being left wet for extended periods of time.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

Residents' water was not in reach and staff were not assisting residents with drinking.

FINDINGS #4:

Six residents' records were reviewed for hydration needs, Resident Council meeting minutes were reviewed, observations were conducted, and family members and residents were interviewed.

All six residents' records did not document a concern regarding water out of reach. Nursing progress notes for a resident admitted to the facility in March 2018, documented multiple times that his/her water and call light were in reach of the resident.

Resident council minutes from March to August 2018 did not document concerns with water out of reach and/or assisting residents with drinking.

During the survey, five residents were observed for water within reach and assistance with drinking, including two meal observations, and no concerns were identified. Water pass was observed and residents were given new ice water and encouraged by staff to drink.

One of the five residents said he/she had no concerns regarding fluids being within reach. Two family members of two of the five residents said these residents' either needed to be reminded to drink and/or had staff assist them with drinking and said staff were good about providing them fluids. Several CNAs and nurses said they assisted residents with fluids, encouraged them to drink, and left water and fluids within reach of the residents. The Director of Nursing and the Administrator said residents had fluids provided to them and were within reach of residents.

The allegation was unsubstantiated due to lack of evidence regarding water not within reach of residents or not assisting residents with fluids.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #5:

A nursing staff member had told other staff to ignore a resident's tremors because they were an attention seeking activity and not real.

FINDINGS #5

All six residents' records were reviewed for medication orders and Medication Administration records, including a resident admitted to the facility on March 2018. All six residents' received medications as ordered.

During the review of the records for one resident, admitted March 2018, physician orders and medication administration records documented the resident had received Indomethacin, Baclofen, and Flexeril for muscle spasms, and they were given as ordered. The nurse progress notes documented several times the resident suffered from spasms and was also offered pain medications when needed and/or if the resident requested them. Physician progress notes, dated 6/12/18, 6/15/18, and 6/28/18, documented the resident and physician discussed muscle spasms and medication regimen and the resident agreed to medication changes to help better control the spasms.

Several nurses and several residents were observed during medication pass and residents received the correct medications as ordered. Several facility staff, including an identified nurse, were observed to interact with residents in a respectful manner.

Several residents and two family members said staff were not abusive or neglectful and they had no concerns regarding staff ignoring medical concerns. Multiple staff said if they suspected or witnessed any form of abuse or neglect, they would report it immediately.

Two CNAs and three nurses who had worked with a resident admitted March 2018, said they did not witness any form of abuse or neglect towards the resident and did not ignore the resident's physical symptoms.

The allegation was unsubstantiated due to lack of evidence of neglect of residents' needs.

ALLEGATION #6:

Residents were not receiving assistance with meals.

FINDINGS #6:

Three out of six residents' records were reviewed for weight loss and eating assistance, family members were interviewed, staff were interviewed, and dining was observed.

Two of three residents' records did not document a concern regarding weight loss or assistance with eating. All three residents' records documented the type of assistance the residents' required for eating. Resident council minutes and Grievances from March to August 2018 did not document concerns with weight loss and/or assisting residents with eating.

During the review of the records for one resident, admitted March 2018, weights were documented and did not vary more than a few pounds from March to August 2018. Meal monitors were documented and no concerns were identified. A Nurses progress note, dated 6/26/18, documented the resident had trouble eating during dinner and was assisted by staff to eat. A Physician order, dated 6/27/18, documented the resident was to receive a restorative dining program daily to help with meals and utensil manipulation.

During the survey, two residents were observed for meal assistance for two meals and staff assisted them as needed and as their care plans directed. Several other residents received assistance with their meals during the two meals and no concerns were identified.

One of the three residents' family member said staff assisted the resident with eating and had no concerns. Several CNAs and nurses said they assisted residents with eating. A Restorative Nurse Assistant said she had assisted a resident, who was admitted in March 2018, with restorative dining program to help the resident eat.

The allegation was unsubstantiated due to lack of evidence regarding lack of assistance with meals.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #7:

Grievances were not acted upon by the facility staff.

FINDINGS #7:

Six residents' records were reviewed for grievances, facility grievances were reviewed, residents were interviewed, the Ombudsman was interviewed, Resident Council meeting minutes were reviewed, and staff were interviewed.

Five out of six residents did not have grievances. Resident council minutes from March to August 2018 documented the facility acted upon individual and group grievances. Grievances were reviewed from March to August 2018 and were acted upon by staff.

During the review of the records for one resident, admitted March 2018, a grievance documented multiple issues were presented by family members on 7/11/18, including communication with staff, neglect, abuse, medication changes, dining room assistance, and call lights. The grievance documented all the areas were addressed and were reported back to the resident and/or family members on 7/11/18, 7/12/18, 7/13/18, and 7/16/18.

One of the six residents said he/she had no concerns and if he/she did then he/she believed staff addressed those concerns quickly. One family member of the six residents said any concerns brought to staff were handled right away and said if they filed a grievance, they were confident it was handled in a timely manner.

The social services assistant said she was involved with the 7/11/18 grievance and the issues had been worked on appropriately. The Director of Nursing and the Administrator said they had worked on investigating the concerns with the 7/11/18 grievance. The Ombudsman said she had attended a care conference in July 2018 with the resident and family members where several concerns were addressed and she noted that all those in attendance had walked away with a good plan in place to address the concerns.

The allegation was unsubstantiated due to lack of evidence regarding grievances not being acted upon.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #8:

Residents were not evaluated correctly when a change of condition occurred.

FINDINGS #8:

Six residents' records were reviewed for changes of condition and staff were interviewed.

Five out of six resident records reviewed did not document a concern regarding evaluations or a change of condition.

During the review of the records for one resident, admitted March 2018, a nurse progress note, dated 7/20/18, documented the resident said he/she felt weak and confused that afternoon, but said he/she had not slept well the night before. The progress note documented the resident was evaluated for breath, pain, bowels, and that a new medication, Cymbalta, had been started that morning and staff would continue to monitor the resident. A nurse progress note, dated 7/21/18, documented the resident was unable to speak, hold his/her head up, and follow instructions. The note documented a family member had come into the facility and requested the resident to be sent to the emergency room and the resident was sent to the emergency room.

Several CNAs said if they noticed a change of condition in residents, they would immediately contact the nurse. Several nurses said when residents experienced a change of condition they evaluated them and acted accordingly, including contacting the physician and family and sending the resident to the emergency room, if necessary.

A nurse said the resident admitted in March 2018 was not acting his/herself and was acting tired. The nurse said they had contacted the physician and informed the family that he/she was sending the resident to the hospital. The nurse said when he/she spoke to the power of attorney (POA), the POA told the nurse to wait to send the resident to the emergency room until another family member, who was already near the facility, could see and assess the resident's condition. The nurse said the ambulance was called and the resident was sent to the emergency room.

The allegation was unsubstantiated due to lack of evidence regarding the lack of evaluation and treatment when a change of condition occurred.

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.

Briar Rose Fenn, Administrator
April 10, 2019
Page 9 of 9

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,

A handwritten signature in black ink, appearing to read "Laura Thompson". The signature is written in a cursive style and is positioned above the typed name.

Laura Thompson, RN, Supervisor
Long Term Care Program

LT/lj