



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
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BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
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October 24, 2018

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

Provider #: 135104

Dear Ms. Bentzler:

On **September 28, 2018**, a survey was conducted at Twin Falls Center by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be one that comprises a pattern that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

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

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **November 5, 2018**. Failure to submit an acceptable PoC by **November 5, 2018**, may result in the imposition of penalties by **November 26, 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 **November 2, 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 **December 28, 2018**. A change in the seriousness of the deficiencies on **November 12, 2018**, may result in a change in the remedy.

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The remedy, which will be recommended if substantial compliance has not been achieved by **December 28, 2018** includes the following:

Denial of payment for new admissions effective **December 28, 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 **March 28, 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 **December 28, 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:

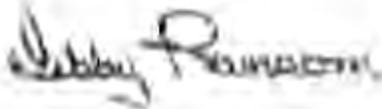
- BFS Letters (06/30/11)

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

This request must be received by **November 5, 2018**. If your request for informal dispute resolution is received after **November 5, 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

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

PRINTED: 01/11/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135104	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/28/2018
NAME OF PROVIDER OR SUPPLIER TWIN FALLS CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 674 EASTLAND DRIVE TWIN FALLS, ID 83301		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS The following deficiencies were cited during an unannounced complaint investigation survey conducted at the facility from September 24, 2018 to September 28, 2018. The surveyors conducting the survey were: Linda Kelly, RN, Team Leader Marcia Mital, RN Abbreviations: ADL = Activity(ies) of Daily Living BM = Bowel movement (stool, feces) BPH = Benign Prostatic Hyperplasia (enlarged prostate gland) cm = centimeters CNA = Certified Nursing Assistant I&A = Incident and Accident DNS = Director of Nursing Services LPN = Licensed Practical Nurse mg = milligrams MDS = Minimum Data Set PDS = Practice Development Specialist PRN = As needed RN = Registered Nurse RRNM = Regional Resource Nurse Manager SC = Staff Coordinator SW = Social Worker UM = Unit Manager	F 000			
F 600 SS=E	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property,	F 600		11/9/18	

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

TITLE

(X6) DATE

Electronically Signed

10/31/2018

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 600	<p>Continued From page 1 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.</p> <p>§483.12(a) The facility must-</p> <p>§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, facility policy review, review of investigations of allegations of abuse and neglect, and staff interview, it was determined the facility failed to ensure residents received the necessary care and services to prevent neglect. This was true for 5 of 12 residents reviewed (#8, #9, #10, #11, and #12). The failure created the potential for harm if residents experienced skin breakdown, infection, embarrassment, or humiliation from being left in wet and soiled incontinence products and bedding. Findings include:</p> <p>The facility's Abuse Prohibition policy, revised 7/1/18, defined neglect as the failure to provide goods and services to a patient that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. This policy was not followed.</p> <p>A Neglect Allegation Summary, undated, included an allegation of neglect by CNA #5 on 9/5/18. The summary stated 2 residents were found by a staff member soaking wet and 1 of the residents also had dried BM on her. The staff member</p>	F 600	<p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Twin Falls Center does not admit that the deficiency listed on this form exists, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency.</p> <p>F600</p> <p>Specific Residents Identified</p> <p>On or before 11/9/18, an investigation of an allegation of neglect involving residents #8, #9, #11 and #12 will be completed by the Center Executive</p>		

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F 600	<p>Continued From page 2</p> <p>stated it appeared they were not changed for several hours.</p> <p>The investigation included resident and staff interviews, dated 9/7/18, which identified 5 residents (#8, #9, #10, #11, and #12) who did not receive incontinence care as needed.</p> <p>The investigation included an undated written statement by UM #1 stating at 5:30 PM on 9/5/18, she asked CNA #5 if she needed help to get residents up, changed, or toileted. The statement documented CNA #5 replied she did not need help and everyone was up and were already changed.</p> <p>A Witness Interview Record for CNA #2, dated 9/7/18, documented on 9/5/18 she saw "multiple" residents did not have their incontinence briefs changed and residents were complaining CNA #5 told them she did not have time to change them.</p> <p>A Witness Interview Record for CNA #6, dated 9/7/18, documented on 9/5/18 between 5:00 and 5:30 PM, Resident #8's spouse asked CNA #5 to change Resident #8 and CNA #5 told him it would be after dinner. CNA #6 stated she assisted CNA #5 to change Resident #8 at approximately 7:30 PM, and Resident #8 was soaked through with urine and feces was coming out of her brief. CNA #6 also stated in the interview Resident #8's skin was irritated and red.</p> <p>The conclusion of the investigation documented, neglect could not be substantiated due to insufficient information, although there was a statement from 1 staff member CNA #5 did not respond to a family member's request to change</p>	F 600	<p>Director. Follow up will be completed including attempts to obtain missing statements from staff and any findings addressed. The allegation was reported to the state on 10/31/18 by the Center Executive Director.</p> <p>Residents #8,9,11 and 12 will be reassessed by the Center Nurse Executive or designee for any adverse effects related to the allegation of neglect and for any needed changes to their plan of care including incontinence care. These assessments and any needed follow up or care plan updates will be completed by the Center Nurse Executive or designee on or before 11/9/18.</p> <p>Resident # 10 discharged on 9/11/18 from the facility.</p> <p>Identification of Other Residents</p> <p>Interviews of residents will be completed on or before 11/9/18 by Social Services staff or designee of all current interviewable residents in the facility regarding abuse or neglect including toileting and personal cares provided by staff to rule out additional allegations. Assessments of current non interviewable residents will be completed on or before 11/9/18 by the Center Nurse Executive or designee to rule out any additional allegations of abuse or neglect.</p>		

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F 600	<p>Continued From page 3</p> <p>Resident #8. The investigation documented CNA #5 was terminated.</p> <p>On 9/26/18 at 9:00 AM, CNA #2, said she was called to work the evening shift on 9/5/18. She arrived for work at 6:00 PM and began making rounds as soon as she arrived. The CNA said she found Resident #9, and her bed, soaked in urine and there was BM going down her leg. CNA #2 said Resident #9 was so wet and soiled, she and the SC gave her a shower that night and had to do a complete bed linen change.</p> <p>On 9/26/18 at 12:58 PM, the SC said she helped CNA #2 give Resident #9 a bath and changed her bed linen sometime between 5:30 and 6:00 PM on 9/5/18. The SC said Resident #9's bed was soaked and soiled with BM. The SC said she was concerned Resident #9 was neglected because she was left laying in the soaked and soiled bed. The SC said she talked to CNA #5 around 8:00 PM on 9/5/18, and CNA #5 said she had not had a chance to go into Resident #9's room, but she received report Resident #9 was changed at 3:00 PM.</p> <p>On 9/27/18 at 10:05 AM, the DNS stated her expectation was for staff to check and change residents incontinence briefs every 2 to 3 hours and to request help if needed.</p>	F 600	<p>Interviews will be completed on or before 11/9/18 by the Center Executive Director or designee of current staff members regarding abuse or neglect including toileting and personal cares provided by staff to rule out additional allegations.</p> <p>Abuse/neglect investigations for the last 60 days of other residents in the facility will be reviewed by the Center Executive Director or designee on or before 11/9/18 to ensure that there are not any additional allegations noted that require additional investigation or follow up and that investigations are complete.</p> <p>Systemic Changes</p> <p>Center Executive Director and Center Nurse Executive will be educated by Regional Staff on or before 11/9/18 regarding the requirement of investigations related to abuse/neglect including investigation of all reported allegations by staff, investigations are reviewed to ensure that all components are completed and statements reviewed prior to the conclusion of the investigation.</p> <p>Facility staff will be educated on or before 11/9/18 by the Center Executive Director or designee regarding the facility abuse/neglect policy including the requirement to immediately stop the abuse, report any allegations to the Center Executive Director and to</p>		

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F 600	Continued From page 4	F 600	<p>immediately remove the employee who is alleged to have committed the abuse. A post test will be completed to validate competency.</p> <p>Beginning 11/10/18, the Center Executive Director or designee will review new reportable investigations for completeness including ensuring that all allegations are investigated prior to the closure of the investigation.</p> <p>Monitoring</p> <p>Beginning the week of 11/10/18, an audit of allegations of abuse or neglect will be reviewed by the Center Executive Director or designee to ensure that allegations were reported timely, that the resident was protected and that the investigation was thorough and complete. Beginning the week of 11/10/18, an interview of 5 residents related to any previously unidentified allegations of abuse or neglect will be completed to ensure that investigations and timely reporting is implemented.</p> <p>Audits will be completed weekly x 4 weeks and then monthly x 2 months. Reviews of each reportable investigation will be completed at the morning clinical meeting for 12 weeks by the facility interdisciplinary team to ensure completeness.</p>		

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F 600	Continued From page 5	F 600	Results of the audits will be reported to the QAPI Committee monthly for 3 months for review and remedial intervention. The Center Executive Director is responsible for monitoring and compliance. The QAPI Committee will re-evaluate the need for further monitoring after 3 months. Date of Compliance 11/9/18		
F 607 SS=E	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on staff interview, review of clinical records, policies, and review of investigations of allegations of abuse and neglect, it was determined the facility failed to follow policies and procedures for investigating instances of potential neglect and abuse. This was true for 5 of 12 residents (#8, #9, #10, #11, and #12) who were identified in an investigation of potential	F 607	F607 Specific Residents Identified On or before 11/9/18, an investigation of an allegation of neglect involving residents #8, #9,#10, #11 and #12 will be	11/9/18	

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F 607	<p>Continued From page 6</p> <p>neglect, and had the potential to affect 34 other residents living in the 400 hall on 9/5/18. The failure created the potential for harm when suspected neglect was not immediately reported to the Administrator or designee, residents were not protected, an investigation of neglect for Residents #8 and #9 was not thorough, an allegation of neglect involving Residents #10 and Resident #11 was not investigated, and an allegation of rough care of residents was not investigated. Findings include:</p> <p>The facility's Abuse Prohibition policy, revised 7/1/18, included the following:</p> <ul style="list-style-type: none"> * Anyone who witnesses an incident of suspected abuse or neglect is to tell the abuser to stop immediately and report the incident to his/her supervisor immediately. * The notified supervisor will report the suspected abuse immediately to the Administrator or designee and other officials in accordance with state law. * The employee alleged to have committed the act of abuse will be immediately removed from duty, pending investigation. * Initiate an investigation within 24 hours of an allegation of abuse that focuses on whether abuse/neglect occurred and to what extent, clinical examination for signs of injuries, and if indicated, causative factors and interventions to prevent further injury. <p>The facility failed to initiate an investigation of suspected neglect on 9/5/18, within 24 hours.</p>	F 607	<p>completed by the Center Executive Director. Follow up will be completed including attempts to obtain missing statements from staff and any findings addressed. The allegation was reported to the state by the Center Executive Director on or before 11/1/18.</p> <p>Residents #8,9,11 and 12 will be reassessed by the Center Nurse Executive or designee for any adverse effects related to the allegation of neglect and for any needed changes to their plan of care including incontinence care. These assessments and any needed follow up or care plan updates will be completed by the Center Nurse Executive or designee on or before 11/9/18.</p> <p>On or before 11/9/18, an investigation of an allegation of rough care of residents will be completed by the Center Executive Director. Follow up will be completed as indicated. The allegation was reported to the State by the Center Executive Director on or before 11/1/18.</p> <p>The Staffing Coordinator, CNA#2 and RN #1 will be educated on or before 11/9/18 regarding the facility abuse policy including the requirement to immediately stop the abuse and report any allegations to the Center Executive Director, and to immediately remove the employee who is alleged to have committed the abuse.</p>		

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F 607	<p>Continued From page 7</p> <p>A Neglect Allegation Summary, undated, included an allegation of neglect by CNA #5 on 9/5/18. The summary stated 2 residents were found by a staff member soaking wet and 1 of the residents also had dried BM on her. The staff member stated it appeared they were not changed for several hours.</p> <p>The investigation included interviews, dated 9/7/18, which identified 5 residents (#8, #9, #10, #11, and #12) and documented multiple residents were not changed, and residents complained they were told by CNA #5 she did not have time to change them. One of the interviews on 9/7/18, also documented CNA #5 was "a little rough with the residents because she was angry."</p> <p>The Neglect Allegation Summary was incomplete. It did not include documented evidence the SC, who witnessed the neglect of Resident #9, or RN #1, who was aware of the suspected neglect for Resident #9 and Resident #10, were interviewed or gave a statement about the potential neglect on 9/5/18.</p> <p>The investigation concluded neglect could not be substantiated due to insufficient information although the facility had a statement from 1 staff member CNA #5 did not respond to a family member's request for Resident #8 to have her incontinence brief changed.</p> <p>CNA #5 was terminated due to performance issues including not addressing Resident #8's family request.</p> <p>The facility's policy related to suspected abuse</p>	F 607	<p>Resident # 10 discharged on 9/11/18 from the facility.</p> <p>Identification of Other Residents</p> <p>Interviews of residents will be completed on or before 11/9/18 by Social Services staff or designee of all current interviewable residents in the facility regarding abuse or neglect including toileting and personal cares provided by staff or rough treatment to rule out additional allegations. Assessments of current non interviewable residents will be completed on or before 11/9/18 by the Center Nurse Executive or designee to rule out any additional allegations of abuse or neglect.</p> <p>Interviews will be completed on or before 11/9/18 by the Center Executive Director or designee of current staff members regarding abuse or neglect including toileting and personal cares provided by staff or rough treatment to rule out additional allegations.</p> <p>Abuse/neglect investigations for the last 60 days of other residents in the facility will be reviewed by the Center Executive Director or designee on or before 11/9/18 to ensure that there are not any additional allegations noted that require additional investigation or follow up and that investigations are complete.</p>		

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F 607	<p>Continued From page 8 and neglect was not followed. Examples include:</p> <p>1. On 9/5/18, suspected neglect was not immediately reported to administration after it was identified.</p> <p>On 9/26/18 at 9:00 AM, CNA #2 said she was called to work the evening shift on 9/05/18. She said she arrived for work at 6:00 PM, and made rounds as soon as she arrived. CNA #2 said she found Resident #9, and her bed, soaked in urine and she had BM down her leg. CNA #2 said Resident #9 was so wet and soiled she and the SC gave her a shower that night and had to do a complete bed linen change.</p> <p>On 9/26/18 at 9:00 AM, CNA #2 said she also found Resident #10 soaked with urine and her urinary catheter was leaking. CNA #2 said she cleaned and changed Resident #10 and also changed the bed linens. CNA #2 said she reported this to RN #1 that evening. CNA #2 said the DNS interviewed her a few days later.</p> <p>On 9/26/18 at 12:58 PM, the SC said she helped CNA #2 give Resident #9 a bath and changed Resident #9's bed sometime between 5:30 and 6:00 PM on 9/5/18. The SC said Resident #9's bed was soaked with urine and soiled with stool. The SC said she was concerned Resident #9 was neglected and was left laying in the soaked and soiled bed.</p> <p>The SC said she talked to CNA #5 around 8:00 PM and CNA #5 said she had not had a chance to go into Resident #9's room, but she received report at 3:00 PM Resident #9 was changed. The SC said she did not report her concern about</p>	F 607	<p>Systemic Changes</p> <p>Center Executive Director and Center Nurse Executive will be educated by Regional Staff on or before 11/9/18 regarding the requirement of investigations related to abuse/neglect including investigation of all reported allegations by staff, investigations are reviewed to ensure that all components are completed and statements reviewed prior to the conclusions of the investigations.</p> <p>Facility staff will be educated on or before 11/9/18 by the Center Executive Director or designee regarding the facility abuse/neglect policy including the requirement to immediately stop the abuse, report any allegations to the Center Executive Director and to immediately remove the employee who is alleged to have committed the abuse. A post test will be completed to validate competency.</p> <p>Beginning 11/9/18, the Center Executive Director or designee will review new reportable investigations for completeness including ensuring that all allegations are investigated prior to the closure of the investigation.</p> <p>Monitoring</p>		

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F 607	<p>Continued From page 9</p> <p>neglect to the nurse that night, but she did report it to the RRNM the next morning.</p> <p>On 9/26/18 at 11:35 PM, RN #1 said she was informed on the evening of 9/5/18, residents were left in urine and soiled clothing/bedding. RN #1 said the facility's policy was to immediately report concerns about abuse or neglect to the UM and the UM would immediately report to the DNS or Administrator. RN #1 said she did not report concerns of neglect on 9/5/18, to the UM, the DNS, or the Administrator.</p> <p>2. CNA #5 was not immediately removed from duty when it was identified there was suspected neglect, per facility policy</p> <p>On 9/26/18 at 12:58 PM, the SC said on 9/5/18 between 5:30 PM and 6:00 PM, she assisted CNA #2 to change and bathe Resident #9 who was soaked with urine and soiled with stool, and they also had to change her bed linens. The SC said she was concerned Resident #9 was neglected by CNA #5, and she talked to CNA #5 around 8:00 PM that night. The SC said she did not feel Resident #9 was in any danger after she was cleaned up and changed, and CNA #5 did work the rest of the shift which ended at 10:00 PM.</p> <p>3. A Neglect Allegation Summary, undated, which occurred on 9/5/18, and involved Resident #8 and Resident #9, included 2 witness interview documents also identifying Resident #10, Resident #11, and Resident #12 as potential victims of neglect.</p> <p>On 9/27/18 at 9:20 AM, the DNS said the</p>	F 607	<p>Beginning the week of 11/10/18, an audit of allegations of abuse or neglect will be reviewed by the Center Executive Director or designee to ensure that allegations were reported timely, that the resident was protected and that the investigation was thorough and complete. Beginning the week of 11/10/18, an interview of 5 residents related to any previously unidentified allegations of abuse or neglect will be completed to ensure that investigations and timely reporting is implemented.</p> <p>Audits will be completed weekly x 4 weeks and then monthly x 2 months. Reviews of each reportable investigation will be completed at the morning clinical meeting for 12 weeks by the facility interdisciplinary team to ensure completeness.</p> <p>Results of the audits will be reported to the QAPI Committee monthly for 3 months for review and remedial intervention. The Center Executive Director is responsible for monitoring and compliance. The QAPI Committee will re-evaluate the need for further monitoring after 3 months.</p> <p>Date of Compliance 11/9/18</p>		

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F 607	Continued From page 10 residents, including Resident #10, Resident #11, and Resident #12, were interviewed, and they did not have any issues. The DNS said she did not review ADL records for Resident #10, Resident #11, and Resident #12, but "it would not be unusual to find a resident wet." The facility did not provide any documented evidence the potential neglect on 9/5/18, of Resident #10, Resident #11, and Resident #12 was investigated. 4. A Witness Interview Record for CNA #6, dated 9/7/18, documented on 9/5/18, CNA #5 was "a little rough with the residents because she was angry." On 9/27/18 at 9:20 AM, the DNS said CNA #6's interview statement that CNA #5 was rough with residents because she was angry, was subjective. The DNS said an allegation of neglect of 2 residents on 9/5/18, was already determined and CNA #5 was fired. The DNS said she did not investigate the allegation of rough care of residents because it was after the fact. The facility did not conduct an investigation of the allegation of rough care of residents on 9/5/18.	F 607			
F 610 SS=E	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.	F 610		11/9/18	

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F 610	<p>Continued From page 11</p> <p>§483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.</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, facility policy review, and review of investigations of allegations of abuse and neglect, it was determined the facility failed to ensure all allegations of abuse and neglect were thoroughly investigated. This was true for 5 of 12 residents reviewed (#8, #9, #10, #11, and #12). The failure created the potential for harm when suspected neglect of Resident #8 and Resident #9 was not thoroughly investigated, and potential neglect of Residents #10, #11, and #12 and potential "rough" care of all 5 residents was not investigated in order to rule out abuse or neglect. Findings include:</p> <p>The facility's Abuse Prohibition policy, revised 7/1/18, stated an investigation would be initiated within 24 hours of an allegation of abuse. The policy stated the investigation focused on whether the abuse/neglect occurred, to what extent, and causative factors and interventions to prevent further injury. The policy also stated the facility was to provide a clinical examination for signs of injuries.</p> <p>A Neglect Allegation Summary, undated, included</p>	F 610	<p>F610</p> <p>Specific Residents Identified</p> <p>On or before 11/9/18, an investigation of an allegation of neglect involving residents #8, #9,#10,#11 and #12 will be completed by the Center Executive Director. Follow up will be completed including attempts to obtain missing statements from staff and any findings addressed. The allegation was reported to the State by the Center Executive Director on or before 11/1/18.</p> <p>Residents #8,9,11 and 12 will be reassessed by the Center Nurse Executive or designee for any adverse effects related to the allegation of neglect and for any other needed changes to their plan of care including incontinence care. These assessments and any needed follow up or care plan updates will be completed by the Center Nurse Executive or designee on or before 11/9/18.</p>		

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F 610	<p>Continued From page 12</p> <p>an allegation of neglect by CNA #5 on 9/5/18. The summary stated 2 residents were found by a staff member soaking wet and 1 of the residents also had dried BM on her. The staff member stated it appeared they were not changed for several hours.</p> <p>The investigation included interviews, dated 9/7/18, which identified 5 residents (#8, #9, #10, #11, and #12) and documented multiple residents were not changed, and residents complained they were told by CNA #5 she did not have time to change them. One of the interviews on 9/7/18, also documented CNA #5 was "a little rough with the residents because she was angry."</p> <p>The Neglect Allegation Summary was incomplete. It did not include documented evidence the SC, who witnessed the neglect of Resident #9, or RN #1, who was aware of the suspected neglect for Resident #9 and Resident #10, were interviewed or gave a statement about the potential neglect on 9/5/18.</p> <p>On 9/26/18 at 9:00 AM, CNA #2, said she arrived for work at 6:00 PM on 9/5/18, and immediately began checking on residents. CNA #2 said she found Resident #9, and her bed, soaked in urine and feces down her leg. CNA #2 said she and the SC gave the resident a shower and had to do a complete bed linen change. CNA #2 said she also found Resident #10 soaked with urine and Resident #10's urinary catheter was leaking. The CNA said she cleaned and changed Resident #10 and also changed the bed linens. CNA #2 said she reported this to RN #1 that night.</p> <p>On 9/26/18 at 12:58 PM, the SC said she helped</p>	F 610	<p>On or before 11/9/18, an investigation of an allegation of rough care of residents will be completed by the Center Executive Director. Follow up will be completed as indicated. The allegation was reported to the State by the Center Executive Director on or before 11/1/18.</p> <p>The Staffing Coordinator, CNA#2 and RN #1 will be educated on or before 11/9/18 regarding the facility abuse policy including the requirement to immediately stop the abuse and report any allegations to the Center Executive Director, and to immediately remove the employee who is alleged to have committed the abuse</p> <p>Resident # 10 discharged on 9/11/18 from the facility.</p> <p>Identification of Other Residents</p> <p>Interviews of residents will be completed on or before 11/9/18 by Social Services staff or designee of all current interviewable residents in the facility regarding abuse or neglect including toileting and personal cares provided by staff or rough treatment to rule out additional allegations. Assessments of current non interviewable residents will be completed on or before 11/9/18 by the Center Nurse Executive or designee to</p>		

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F 610	<p>Continued From page 13</p> <p>CNA #2 give Resident #9 a bath and change her bed linens sometime between 5:30 and 6:00 PM on 9/5/18. The SC said Resident #9 was soaked with urine and soiled with stool.</p> <p>On 9/26/18 at 11:35 PM, RN #1 said she was informed on the evening of 9/5/18, residents were left in urine and soiled clothing/bedding. RN #1 said the facility's policy was to immediately report concerns about abuse or neglect to the UM, and the UM would immediately report to the DNS or the Administrator. RN #1 said she did not report concerns of neglect on 9/5/18 to the UM, the DNS, or the Administrator.</p> <p>On 9/27/18 at 9:20 AM, the DNS said the investigation of the allegation of neglect on 9/5/18, was started on 9/6/18, when she heard about it. The DNS said she was part of the investigation along with the Administrator and the SW. She said all of the residents, including Resident #10, Resident #11, and Resident #12, were assessed and found without problems. She stated the SW talked with the residents and they did not have any issues. The DNS said she did not review ADL records for Resident #10, Resident #11, and Resident #12, but "it would not be unusual to find a resident wet." The DNS said the comment that CNA #5 was rough with residents, was subjective. The DNS said she did not ask the staff member what was meant by rough because CNA #5 was fired and it was after the fact.</p> <p>Documentation of the assessments for Resident #10, Resident #11, and Resident #12 were requested, however, none were provided.</p>	F 610	<p>rule out any additional allegations of abuse or neglect.</p> <p>Interviews will be completed on or before 11/9/18 by the Center Executive Director or designee of current staff members regarding abuse or neglect including toileting and personal cares provided by staff or rough treatment to rule out additional allegations.</p> <p>Abuse/neglect investigations for the last 60 days of other residents in the facility will be reviewed by the Center Executive Director or designee on or before 11/9/18 to ensure that there are not any additional allegations noted that require additional investigation or follow up and that investigations are complete.</p> <p>Systemic Changes</p> <p>Center Executive Director and Center Nurse Executive will be educated by Regional Staff on or before 11/9/18 regarding the requirement of investigations related to abuse/neglect including investigation of all reported allegations by staff, investigations are reviewed to ensure that all components are completed and statements reviewed prior to the conclusions of the investigations.</p> <p>Facility staff will be educated on or before</p>		

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F 610	Continued From page 14	F 610	<p>11/9/18 by the Center Executive Director or designee regarding the facility abuse/neglect policy including the requirement to immediately stop the abuse, report any allegations to the Center Executive Director and to immediately remove the employee who is alleged to have committed the abuse. A post test will be completed to validate competency.</p> <p>Beginning 11/10/18, the Center Executive Director or designee will review new reportable investigations for completeness including ensuring that all allegations are investigated prior to the closure of the investigation.</p> <p>Monitoring</p> <p>Beginning the week of 11/10/18, an audit of allegations of abuse or neglect will be reviewed by the Center Executive Director or designee to ensure that allegations were reported timely, that the resident was protected and that the investigation was thorough and complete. Beginning the week of 11/10/18, an interview of 5 residents related to any previously unidentified allegations of abuse or neglect will be completed to ensure that investigations and timely reporting is implemented.</p> <p>Audits will be completed weekly x 4 weeks and then monthly x 2 months. Reviews of each reportable investigation will be completed at the morning clinical</p>		

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F 610	Continued From page 15	F 610	meeting for 12 weeks by the facility interdisciplinary team to ensure completeness. Results of the audits will be reported to the QAPI Committee monthly for 3 months for review and remedial intervention. The Center Executive Director is responsible for monitoring and compliance. The QAPI Committee will re-evaluate the need for further monitoring after 3 months. Date of Compliance 11/9/18		
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, record review, and staff interview, it was determined the facility failed to provide care and ordered services for 2 of 12 residents (#2 and #3) who were reviewed. The failure increased the potential for Resident #2 to develop skin breakdown when her protective boots were not in place as ordered, and for Resident #3 to experience undetected	F 684	F 684 Specific Residents Identified One or before 11/9/18, resident #2 will be assessed by the Center Nurse Executive or designee for adverse effects related to the protective boots not being in place as	11/9/18	

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F 684	<p>Continued From page 16</p> <p>neurological changes when neurological assessments were not performed as ordered after unwitnessed falls. Finding include:</p> <p>1. Resident #3 was admitted to the facility on 6/15/18, with multiple diagnoses including Alzheimer's disease and BPH with lower urinary tract symptoms. Hospice care was in place when he was admitted to the facility.</p> <p>An admission MDS assessment, dated 6/22/18, documented Resident #3 had severely impaired cognition, he wandered on 1-3 days out of 7 days, which placed him at significant risk of getting to a potentially dangerous place, he needed extensive assistance from 1-2 people for all ADLs, he had limited range of motion in both lower extremities, and he had fallen prior to admission to the facility and had 1 fall with minor injury after admission to the facility.</p> <p>Resident #3's care plan, dated 6/16/18, documented he had a history of falls and he was at risk for falls.</p> <p>Resident #3's I&A reports included a Risk Management System Checklist. The Checklist documented neurological checks, or assessments, were to be done for all falls not witnessed by staff, and for head injuries. The checklist documented neurological checks were to be done every 30 minutes times 4, then every hour times 4, then every 4 hours times 6.</p> <p>Resident #3's I&A reports documented his neurological status was not assessed or the assessments were incomplete when he had unwitnessed falls on 7/5/18, 7/26/18, 8/9/18, and</p>	F 684	<p>ordered. Follow up will be completed as indicated including the care plan and Kardex being updated to reflect the resident's current status.</p> <p>Resident #3 discharged from the facility on 10/22/18</p> <p>Identification of Other Residents</p> <p>On or before 11/9/18, the Center Nurse Executive or designee will review resident care plans and their Kardex for accuracy related to pressure injury prevention. Resident care plans and/or Kardex that have identified discrepancies will be revised to reflect the resident's current status and follow up completed by the nurse manager or designee to reflect resident current status and care and services provided. A bedside review will be completed on or before 11/9/18 by the Center Nurse Executive or designee of residents with orders for devices related to pressure injury prevention to ensure that they are in place.</p> <p>On or before 11/9/18, a review of the falls that occurred within the last 30 days will be completed by the Center Nurse Executive or designee to ensure that neurological evaluations were completed as indicated. Follow up neurological evaluations will be completed by the Center Nurse Executive or designee on or before 11/9/18 with any additional follow</p>		

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F 684	<p>Continued From page 17 8/11/18. The I&A reports included the following:</p> <ul style="list-style-type: none"> * 7/5/18 at 2:00 PM - no neurological checks were completed. * 7/26/18 at 9:30 PM - none of the 4 hour neurological checks were completed, for a total of 6 missing checks. * 8/9/18 at 1:30 PM - no neurological checks were completed. * 8/11/18 at 2:35 PM - the last 4 every 4 hour neurological checks were not completed. <p>On 8/28/18 at 1:32 PM, the PDS said she would look for documentation Resident #3's neurological checks were done on 7/5/18, 7/26/18, 8/9/18, and 8/11/18. At 3:25 PM, the PDS said she did not find any other documentation the neurological checks were completed.</p> <p>2. Resident #2 was readmitted to the facility on 9/11/18, with diagnoses which included dementia and reduced mobility.</p> <p>Resident #2's physician orders, documented a 9/20/18 order for Sage boots (a cushioned boot to protect the feet and heels from skin injury) to bilateral heels at all times when she was in her wheelchair.</p> <p>A care plan, dated 5/11/18, and revised on 9/27/18, documented Resident #2 had skin breakdown and Sage boots were to be on when she was out of bed.</p>	F 684	<p>up completed as indicated by the review.</p> <p>Systemic Changes</p> <p>On or before 11/9/18, the Practice Development Specialist or designee will provide education to nursing staff regarding the center's policy for following the interventions listed on the care plan and Kardex. Education of the licensed nurses will be completed on or before 11/9/18 by the Practice Development Specialist or designee regarding the completion of all parts of the Risk Management System Checklist including neuro checks after a fall.</p> <p>Beginning 11/10/18, a nurse manager or designee will review the comprehensive plan of care quarterly based on the MDS schedule to ensure that the care plan and Kardex are accurate regarding pressure injury prevention and review at the bedside that interventions are in place. Any identified discrepancies will be corrected at that time.</p> <p>Monitoring</p> <p>Beginning the week of 11/10/18 audits of 6 resident's care plans and Kardex will be reviewed by the Center Nurse Executive or designee to ensure that the residents care plan has been updated to accurately reflect the residents' current</p>		

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F 684	Continued From page 18 A Skin Integrity Report, dated 9/20/18, documented Resident #2 had a blister on her left heel. Resident #2 was observed on 9/25/18 at 8:12 AM, sitting up in her wheelchair. The Sage boots were not on her feet. The boots were on a table next to a TV in her room. Resident #2 was observed on 9/25/18 at 10:24 AM, sitting in her wheelchair in her room without the boots on her feet. On 9/27/18 at 11:20 AM, CNA #3 said she had not put the boots on Resident #2 when she got her up on 9/25/18. The CNA said she did not know Resident #2 was supposed to wear the boots because it was not on the Kardex (a document which listed cares and equipment for individual residents). On 9/28/18 at 9:36 AM, the RRNM, stated the boots were not on Resident #2's Kardex on 9/25/18.	F 684	status. Follow up for identified residents will be completed as indicated. Beginning the week of 11/10/18, audits of each Risk Management System report will be completed by the Center Nurse Executive or designee to ensure accuracy and completion specifically completion of the Neuro checks as applicable. Audits will be completed weekly X 4 then Monthly X 2. Results will be reported to the QAPI Committee meeting monthly for 3 months for review and remedial interventions. The Center Nurse Executive is responsible for monitoring and compliance. The QAPI Committee will re-evaluate the need for further monitoring after 3 months. Date of Compliance 11/9/18		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent	F 686		11/9/18	

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F 686	<p>Continued From page 19 with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. 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 a physician's order for a Registered Dietician's recommended supplement to aid in wound healing for 1 of 2 residents (Resident #2) who were reviewed for pressure ulcers. This had the potential to decrease and delay wound healing and increase the risk for infection and complications related to the wound. Findings include:</p> <p>Resident #2 was readmitted to the facility on 9/11/18, with diagnoses which included dementia and reduced mobility.</p> <p>A Skin Integrity Report, dated 9/11/18, documented Resident #2 had an unstageable wound to her left buttock which measured 2 cm by 1 cm.</p> <p>A Nutrition Progress Note, dated 9/18/18, stated Resident #2 required increased nutrition for wound healing and recommended a house supplement BID (twice a day) to promote wound healing through nutrition.</p> <p>Resident #2's record included a Physician's order summary report, dated 9/26/18, which did not include an order for the nutrition supplements recommended for wound healing.</p> <p>On 9/27/18 at 4:15 PM, the RRNM stated, the dietician's recommendation was sent to the</p>	F 686	<p>F686</p> <p>Specific Residents Identified</p> <p>Resident # 2's skin will be assessed on or before 11/9/18 by the Center Nurse Executive or designee, for any adverse effects from the failure to implement the dietician's recommendation for a supplement to aid in wound healing and any findings addressed.</p> <p>Resident #2 will be reviewed on or before 11/9/18 by the Center Nurse Executive and the Center Registered Dietician for the continued need for a supplement. Any recommendations will be implemented.</p> <p>Identification of Other Residents</p> <p>On or before 11/9/18, current residents' skin will be assessed by the Center Nurse Executive or designee to identify any previously unidentified skin impairments.</p> <p>A review of Dietician recommendations from the last 60 days will be completed on or before 11/9/18 by the Center Nurse Executive or designee to ensure that all recommendations were reviewed with the</p>		

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F 686	Continued From page 20 physician and the physician signed it agreeing with the recommendation on 9/21/18. He stated someone had placed it in the chart, but had not written the order for the supplement.	F 686	<p>physician and any orders that were obtained were implemented. Follow-up including physician notification, change in treatment, or care planned intervention will be completed by the Center Nurse Executive or designee on or before 11/9/18.</p> <p>Systemic Changes</p> <p>Nursing Staff will be re-educated by the Practice Development Specialist or designee on or before 11/9/18 regarding the Genesis Skin Care Delivery process that includes but is not limited to pressure ulcer prevention measures including supplements and documentation requirements.</p> <p>Monitoring</p> <p>Beginning the week of 11/10/18, an audit of 5 residents will be completed by the Center Nurse Executive or designee to ensure that there are no unidentified skin impairments, that recommendations/interventions including the dietician recommendations have been reviewed by the physician, any orders are in place, and that skin integrity care plans are in place.</p> <p>These audits will be completed weekly X 4 weeks and then monthly X 2 months. The results of these audits will be</p>		

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F 686	Continued From page 21	F 686	reported to the QAPI Committee for review monthly for 3 months for review and remedial intervention. The Center Nurse Executive is responsible for monitoring and follow-up. The QAPI Committee will re-evaluate the need for further monitoring after 3 months. Date of Compliance 11/9/18		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, facility policy review, and review of I&A reports, it was determined the facility failed to ensure each resident received adequate supervision. This was true for 1 of 8 residents (Resident #3) who were reviewed for supervision. Failure to provide adequate supervision created the potential for harm if the resident had falls or accidents that resulted in injury or death. Findings include: Resident #3 was admitted to the facility on 6/15/18, with multiple diagnoses including Alzheimer's disease, and BPH with lower urinary tract symptoms. Hospice care was in place when	F 689	F689 Specific Residents Identified Resident #3 discharged from the facility on 10/22/18. Identification of Other Residents On or before 11/9/18 an audit will be completed of current residents by the Center Nurse Executive or designee, to identify residents at risk for falls.	11/9/18	

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F 689	<p>Continued From page 22 he was admitted to the facility.</p> <p>An admission MDS assessment, dated 6/22/18, documented Resident #3 had severely impaired cognition, he wandered on 1-3 days out of 7 days, which placed him at significant risk of getting to a potentially dangerous place, he needed extensive assistance from 1-2 people for all ADLs, he had limited range of motion in both lower extremities, and he had fallen prior to admission to the facility and had 1 fall with minor injury after admission to the facility. The assessment also documented Resident #3 was on an antipsychotic medication on a routine basis and he received antidepressant medication.</p> <p>Resident #3's care plan documented he was at risk for falls and had a history of falls related to cognitive loss, lack of safety awareness, limited self-mobility, pain, gout, depression, and refusals of care.</p> <p>Resident #3's care plan included the following interventions:</p> <ul style="list-style-type: none"> * Assist with toileting every 2 hours and PRN as tolerated initiated on 6/20/18. On 8/13/18, the care plan was revised for Resident #3 to be toileted "approximately" every 2 hours and PRN as tolerated. * Low bed with mats on the floor on the right and left side of his bed, initiated on 8/23/18. * Care conference with family regularly and PRN to review Resident #3's safety and behaviors and his plan of care, initiated on 8/3/18. 	F 689	<p>Residents at risk for falls will be reviewed at bedside to ensure that interventions are in place and that care plans/Kardex are updated to reflect the current resident status and follow up corrections completed as indicated.</p> <p>On or before 11/9/18 residents will be reviewed for the level of supervision required by the Center Nurse Executive or designee. The Center Nurse Executive or designee will update the residents' care plan and Kardex to reflect resident's required level of supervision on or before 11/9/18.</p> <p>Systemic Changes</p> <p>On or before 11/9/18, the Practice Development Specialist or designee will provide education to Licensed Nursing Staff regarding resident fall risk, required supervision per resident care plan/Kardex, required documentation of supervision, implementation of preventative interventions and post fall assessments. Competency will be validated by a post test administered on or before 11/9/18 by the Practice Development Specialist or designee.</p> <p>On or before 11/9/18, the Practice Development Specialist or designee will provide education to CNA staff related to reviewing the KARDEX prior to starting shift assignment for care instructions including level of supervision, required</p>		

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F 689	<p>Continued From page 23</p> <p>* Provide increased supervision with 15 minute checks, initiated on 7/22/18. On 8/23/18, the care plan was revised for 15 minute checks while he was in bed and one on one supervision while out of bed.</p> <p>The One on One Observation policy, revised 11/28/16, documented:</p> <p>* The person observing must be in the patient's room with complete view of the patient at all times or during times assessed as needing one on one observation.</p> <p>* Verification of constant observation/supervision at least every shift.</p> <p>Resident #3 had 20 I&A reports between 6/17/18 and 9/24/18, related to falls. Resident #3 had falls documented on 6/18/18, 6/21/18, 7/4/18, 7/5/18, 7/20/18, 7/22/18, 7/26/18, 8/3/18, 8/6/18, 8/9/18, 8/11/18, 8/15/18, 8/17/18, 9/23/18, and 9/24/18. Resident #3 had 2 falls documented on 8/12/18 and 8/21/18.</p> <p>The I&A reports documented Resident #3 had skin tears as a result of falls on 6/18/18, 8/3/18, 8/12/18, and 8/21/18. Resident #3 had redness to his back from a fall on 8/11/18. Resident #3 had a bruise to his leg after a fall on 8/14/18.</p> <p>The facility did not implement 15 minutes checks between 7/23/18, and Resident #3's fall on 8/21/18, as care planned on 7/22/18. After the second fall on 8/21/18, the 15 minute checks were inconsistent. In addition, there was no documentation in Resident #3's record one on one supervision, care planned on 8/21/18, was</p>	F 689	<p>documentation of supervision and fall prevention interventions.</p> <p>Beginning 11/10/18, CNA staff will review the KARDEX with the oncoming shift during the shift to shift report, the unit nurse will be responsible for monitoring compliance with this process.</p> <p>On or before 11/9/18, the Center Nurse Executive or designee will complete a center round to validate that care planned fall interventions are implemented at the bedside, required documentation of supervision is in place and follow up will be completed as indicated for any identified concerns.</p> <p>On or before 11/9/18, the Center Nurse Executive or designee will review residents with falls in daily clinical meeting for root cause and to ensure the care plan has been updated with appropriate interventions. Follow up will be completed as indicated.</p> <p>Beginning 11/10/18 residents who have a fall will be reviewed by the IDT in the weekly Customer at Risk meeting to evaluate effectiveness of interventions implemented post fall.</p> <p>Monitoring</p> <p>Beginning the week of 11/10/18, audits of</p>		

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F 689	Continued From page 24 provided on 8/25/18 through 9/2/18 (9 days), 9/6/18, 9/7/18, 9/9/18, 9/10/18, 9/12/18, 9/16/18 through 9/19/18 (4 days), 9/21/18, or 9/23/18. On 9/26/18, the RRNM said daily staffing assignments included information about which staff member was assigned as the one on one. He said daily staffing assignments were not part of the resident's record, but one on one supervision should be documented in nursing notes. The RRNM also said the facility did not have a policy for 15 Minute Checks. On 9/28/18 at 1:51 PM, the PDS provided a stack of 15 Minute Check flowsheets and said she did not find 15 Minute Check flowsheets prior to 8/21/18.	F 689	5 residents with falls will be completed by the Center Nurse Executive or designee, to ensure that resident fall risk has been reviewed and care plans have been updated to reflect the resident's current status with interventions implemented at the bedside as indicated. Any required documentation of increased supervision will also be reviewed to ensure that it is complete. Audits will be completed weekly X 4 then Monthly X 2. Results will be reported to the QAPI Committee meeting monthly for 3 months for review and remedial interventions. The Center Nurse Executive is responsible for monitoring and follow-up. The QAPI Committee will re-evaluate the need for further monitoring after 3 months. Date of Compliance 11/9/18		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic	F 758		11/9/18	

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F 758	<p>Continued From page 25</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that---</p> <p>§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;</p> <p>§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;</p> <p>§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and</p> <p>§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.</p> <p>§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review and family and staff</p>	F 758			
			F758		

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F 758	<p>Continued From page 26</p> <p>interview, it was determined the facility failed to ensure a consent was obtained prior to administration of an antipsychotic medication. This was true for 1 of 4 residents (Resident #3) who was reviewed for psychotropic medication use. The failure created the potential for harm if the resident experienced adverse reactions from unnecessary medications. Findings include:</p> <p>Resident #3 was admitted to the facility on 6/15/18, with multiple diagnoses including Alzheimer's disease, dementia with behavioral disturbances, and adjustment disorder with depressed mood. Hospice care was in place when he was admitted to the facility.</p> <p>An admission MDS assessment, dated 6/22/18, documented Resident #3's had cognition which was severely impaired, he continuously had difficulty focusing his attention, which significantly interfered with his care and activities or social interaction, he wandered 1-3 days out of 7 days, and he was on an antipsychotic medication.</p> <p>Resident #3's current care plan, dated 6/16/18, included the following:</p> <p>* He exhibited or was at risk for distressed/fluctuating mood symptoms related to depression and dementia with behavioral disturbances. Interventions included administration of antipsychotic and antidepressant medications as ordered and to monitor for signs and symptoms of worsening sadness and depression.</p> <p>* He was at risk for complications related to the use of psychotropic medications. Interventions</p>	F 758	<p>Specific Residents Identified</p> <p>Resident # 3 discharged from the facility on 10/22/18.</p> <p>Identification of Other Residents</p> <p>On or before 11/9/18, the Center Nurse Executive or designee will conduct an audit of residents with orders for psychotropic medications to ensure that signed consents are completed. Any findings will be addressed on or before 11/9/18.</p> <p>Systemic Changes</p> <p>On or before 11/9/18, the Practice Development Specialist or designee will provide education to licensed nursing staff regarding the requirement that consent must be obtained prior to the administration of an antipsychotic medication.</p> <p>Monitoring</p> <p>Beginning the week of 11/10/18, the Center Nurse Executive or designee will conduct a weekly audit of 5 residents with orders for antipsychotic medications to ensure that there are signed consents in their medical record.</p>		

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F 758	<p>Continued From page 27 included completing behavior monitoring flowsheets, gradual dose reductions as ordered, and provide informed consent to the resident or healthcare decision maker.</p> <p>Resident #3's admission physician orders, dated 6/15/18, included:</p> <ul style="list-style-type: none"> * Lexapro 20 mg (antidepressant) 1 tablet by mouth twice a day; * Seroquel 50 mg (antipsychotic) by mouth every morning and 200 mg by mouth every evening for Alzheimer's with behavioral disturbances. <p>A Physician Progress Note, dated 6/26/18, documented Resident #3 had a long-standing history of Alzheimer's dementia and had progressed to a nonverbal, nonambulatory, and incontinent state. The physician reviewed the medications with Resident #3's daughter who lived out of state. The physician stated "He is on suprathereapeutic doses of antidepressants and antipsychotic medications, but family has been resistant to reducing these medications without consulting his neurologist in Montana first." Suprathereapeutic doses are medications administered at levels greater than would be used in actual treatment of a medical condition. The physician stated Resident #3's daughter also insisted if he was asleep, he should be awakened and given the medications. The physician documented he had attempted to contact the neurologist, but the neurologist was not available.</p> <p>On 6/29/18, Resident #3's neurologist decreased the Seroquel to 25-50 mg at noon and 100 mg at</p>	F 758	<p>Audits will be completed weekly X 4 then Monthly X 2. Results will be reported to the QAPI Committee monthly for 3 months for review and remedial interventions. The Center Nurse Executive is responsible for monitoring and compliance. The QAPI Committee will re-evaluate the need for further monitoring after 3 months.</p> <p>Date of Compliance 11/9/18</p>		

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

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F 758	<p>Continued From page 28 bedtime.</p> <p>A Progress Note by LPN #2, dated 6/30/18 at 3:18 PM, documented Resident #3 had behavioral symptoms of agitation and psychosis in the morning and this was reported to the hospice agency at 3:00 PM. LPN #2 documented Resident #3's daughter, who lived locally, was notified at 3:30 PM.</p> <p>A Progress Note by LPN #1, dated 6/30/18 at 3:51 PM documented, she reached out to the hospice agency to update them about Resident #3's worsening physical aggressive behavior. LPN #1 documented Hospice RN #1 had good rapport with Resident #3's daughter, and was reaching out to her to see if Ativan could be given to Resident #3. The progress note documented Hospice RN #1 will follow up with the floor nurse.</p> <p>A Progress Note by LPN #2, dated 6/30/18 at 3:57 PM, documented she reached out to the hospice agency to update them about Resident #3's worsening physical aggressive behavior. LPN #2 documented Hospice RN #1 had good rapport with Resident #3's daughter and was reaching out to her to see if PRN Ativan could be given to Resident #3. The progress note documented Hospice RN #1 will follow up with the floor nurse. This note was the same as LPN #1's entry 6 minutes earlier.</p> <p>A hospice progress note, dated 6/30/18, documented Hospice RN #1 received a report from an LPN at the facility Resident #3 had increased behaviors and he was not easily directed, and was combative with staff. Hospice</p>	F 758			

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(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 758	<p>Continued From page 29</p> <p>RN #1 documented she notified the physician and received an order for Ativan 0.5 mg, 1 tablet by mouth every 6 hours as needed. Hospice RN #1 documented she notified facility staff of the new order and to administer the medication and call back in 1 hour if the Ativan was not effective. The note stated Hospice RN #1 called Resident's daughter who was the power of attorney, and she was agreeable to the medication.</p> <p>Resident #3's clinical record included a consent form for the Ativan, dated 6/30/18. LPN #1 and LPN #2 signed Resident #3's daughter, who lived locally, had given verbal consent for the Ativan.</p> <p>Resident #3's Medication Administration Record documented he was given the Ativan on 6/30/18 at 4:20 PM.</p> <p>A Progress Note by LPN #2, dated 7/1/18 at 7:18 AM, documented Resident #3 continued to be combative towards staff, was intrusive, and hard to redirect. A new order was received from the hospice agency for Haldol 2 mg three times a day.</p> <p>A Hospice order for Resident #3, dated 7/1/18, documented to start Haldol 2 mg 1 tablet PO [by mouth] three times daily for agitation/behaviors.</p> <p>A Progress Note by LPN #2, dated 7/1/18 at 3:18 PM documented, the first dose of Haldol was given at 12:00 PM.</p> <p>A Progress Note by the physician dated 7/2/18 documented, he was notified over the weekend Resident #3 was having increased agitation and physical aggression toward staff, was intrusively</p>	F 758			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135104	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/28/2018
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F 758	<p>Continued From page 30</p> <p>wandering into other residents bedrooms and was unable to be redirected. The physician further documented, due to Resident #3's psychosis, Haldol was adminisitered which was effective, but not sedating. He documented Resident 3's behaviors were markedly improved over the last 24 hours. The physician documented Resident #3 awakened easily in the morning and was able to form words and communicate more effectively than he had at previous encounters, and appeared to be much more effective than the high-dose Seroquel. The physician recommended no changes in the Haldol dose .</p> <p>Resident #3's record included a consent form for the Haldol dated 7/1/18. LPN #1 and LPN #2 signed the form which documented Resident #3's daughter, who lived locally, had given verbal consent for the Haldol.</p> <p>On 9/27/18 at 4:10 PM, LPN #1 reviewed both consents. LPN #1 said on 6/30/18, the Hospice nurse contacted Resident #3's daughter first and then she (LPN #1), contacted the local daughter and obtained verbal consent for the Ativan. LPN #1 stated she contacted Resident #3's local daughter and obtained verbal consent for the Haldol. LPN #1 said she contacted the local daughter because she was listed as Resident #3's first emergency contact.</p> <p>On 9/28/18 at 9:55 AM, Resident #3's daughter who lived out of town, said the Hospice nurse called her on 6/30/18 about his behaviors and she consented to the Ativan. The daughter said she did not consent to Haldol on 7/1/18 and she did not learn about the Haldol until 2 days after it</p>	F 758			

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

PRINTED: 01/11/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135104	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/28/2018
NAME OF PROVIDER OR SUPPLIER TWIN FALLS CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 674 EASTLAND DRIVE TWIN FALLS, ID 83301		
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F 758	<p>Continued From page 31 was started.</p> <p>On 9/28/18 at 1:30 PM, Resident #3's daughter who lived locally, said she did not give consent for the Ativan or the Haldol and her sister was the one who authorized all of Resident #3's medications.</p> <p>On 9/28/18 at 3:08 PM, LPN #2 said she talked with the hospice nurse on the morning of 7/1/18, because the Ativan was not helping, Haldol was suggested, and the hospice nurse said she would contact Resident #3's daughter who lived out of state and the physician. LPN #2 said the physician ordered the Haldol and she obtained verbal, not written, consent from Resident #3's daughter who lived locally when she was in the facility later that morning. LPN #2 said she did not get written consent even though the daughter was in the building.</p> <p>On 9/28/18 at 3:12 PM, Hospice RN #1 said she knew the out-of-town daughter was Resident #3's power of attorney, and the daughter consented to the Ativan on 6/30/18 and to the Haldol on 7/1/18. Hospice RN #1 said she failed to document anything about the Haldol.</p> <p>Neither of Resident #3's daughters consented to the use of Haldol.</p>	F 758			



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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E-mail: fsb@dhw.idaho.gov

April 5, 2019

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

Provider #: 135104

Dear Ms. Bentzler:

On **September 28, 2018**, an unannounced on-site complaint survey was conducted at Twin Falls Center. The complaint was investigated during an unannounced complaint investigation survey conducted at the facility from September 24, 2018 to September 28, 2018. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007677

ALLEGATION:

The facility did not check on or change residents through the night and left them in wet and soiled incontinence products.

FINDINGS:

The clinical records of 12 residents were reviewed. Grievance files, Incident and Accident (I&A) reports, Resident Council minutes, and investigations of allegations of Abuse/Neglect, for October 2017 through September 2018, were also reviewed. Interviews were conducted with ten residents, two family members, and multiple staff members, including nurses and Certified Nursing Assistants (CNAs), the Staff Coordinator (SC), and the Director of Nursing Services (DNS).

Lori Bentzler, Administrator
April 5, 2019
Page 2 of 2

One resident's clinical record documented he frequently refused personal care and was often combative when staff attempted to assist him with toileting or provide incontinence care, even when they used care planned approaches for sweets and conversation about his dog. His record documented he frequently wandered about the facility in his wheelchair, refused to lay down at night, and preferred to stay up in his wheelchair.

A summary related to an investigation of an allegation of neglect in September 2018 documented a CNA found two residents whose incontinence briefs had not been changed for hours. The incontinence briefs for both residents were soaking wet, the bed linens for one of the residents were soaking wet, and dried feces was found on one of the residents. The investigation itself included staff interviews in which 5 residents in total were identified as not receiving incontinence care as needed. The clinical records of those five residents documented all of them needed the staff to provide incontinence care.

One CNA said shortly after she arrived for work one evening she found a resident who was so wet and soiled she needed a shower and a complete bed change. The SC said she helped the CNA give the resident a shower and change the bed linens. The DNS said she expected the staff to check and change residents' incontinence briefs every 2 to 3 hours, and more often when needed.

Based on the investigative findings, incontinence care was not consistently provided in a timely manner and some residents were left in wet and soiled incontinence products and/or bedding. The allegation was substantiated and the facility was cited for deficient practice.

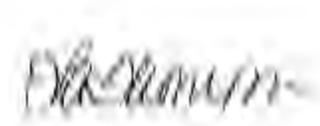
CONCLUSIONS:

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

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

Lori Bentzler, Administrator
April 5, 2019
Page 3 of 2

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April 10, 2019

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

Provider #: 135104

Dear Ms. Bentzler:

On **September 24, 2018** through **September 28, 2018**, an unannounced on-site complaint survey was conducted at Twin Falls Center. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007782

ALLEGATION #1:

The facility failed to provide appropriate incontinence care and appropriately maintain a CPAP device.

FINDINGS #1:

Interviews were conducted with 10 residents, two family members, and multiple staff members and 12 resident records were reviewed. Observations were conducted throughout the facility, including observations on the night shift. Facility grievances were reviewed.

One resident's record, who used a CPAP machine, was reviewed and there was no documentation of a broken CPAP in the resident's record or observed in the facility. Two other residents with CPAP machines were reviewed without evidence of deficient practice.

Lori Bentzler, Administrator
April 10, 2019
Page 2 of 4

Observations on the night shift and resident/staff interviews did not identify concerns with staffing or incontinence care, particularly on the night shift.

Although the allegations were substantiated, the facility was not cited with deficient practice because the investigation did not substantiate current deficient practice.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The facility failed to ensure a PICC line was properly maintained to prevent infection.

FINDINGS #2:

During the investigation interviews were conducted with 10 residents, two family members, and multiple staff members. Observations were conducted throughout the facility, including observations on the night shift. There were 12 resident records reviewed.

A facility investigation was reviewed for one resident which stated the dressing and needless connectors were not changed as ordered by the physician. The facility in-serviced and completed competencies for all nursing staff on Peripherally Inserted Central Catheter (PICC) lines and intravenous (IV) lines. The facility completed audits of all residents with PICC lines. Licensed nursing staff were interviewed about PICC line care and the staff answered appropriately. There were no current residents in the facility with IV or PICC lines during the survey.

The allegation was substantiated but the facility was not cited with deficient practice because no current deficient practice was identified.

CONCLUSIONS:

Substantiated. No deficiencies related to the allegation are cited.

ALLEGATION #3:

The facility failed to keep a clean environment.

FINDINGS #3:

During the investigation interviews were conducted with 10 residents, two family members, and

multiple staff members. Observations were conducted throughout the facility, including observations on the night shift. There were 12 resident records reviewed.

A facility grievance was reviewed which stated a dirty bedpan was left in a residents' room. A CNA had forgotten to empty the bedpan and dispose of the dirty brief after providing care to the resident. Observations during the survey revealed the environment was clean and no dirty bedpans were observed. There were 12 residents reviewed for cares without concerns.

The allegation was substantiated, but the facility was not cited with deficient practice because there was no current deficient practice.

CONCLUSIONS:

Substantiated. No deficiencies related to the allegation are cited.

ALLEGATION #4:

The facility failed to ensure resident's family members were informed for significant changes in the resident's condition.

FINDINGS #4:

During the investigation interviews were conducted with 10 residents, two family members, and multiple staff members. Observations were conducted throughout the facility, including observations on the night shift. There were 12 resident records reviewed.

A facility investigation of one resident stated they had experienced a fractured ankle. The resident was interviewed as part of the investigation and stated she had pain in her ankle for about 3 weeks, but just reported a few days ago and asked for the physician to look at it. The resident stated she was working with therapy about 3 weeks ago when she ran into another wheelchair pedal while in her electric wheelchair. The resident reported she did not recall having any pain to her left foot/ankle at that time. She stated she had been careful to not hit anything since then and did not recall how long after that the pain in her ankle started. The resident reported she had not had any accidents/falls. She stated she was unsure what could have caused the fracture. The resident denied any abuse from staff or others in the facility.

The resident's Medication Administration Record for November 2017 did not include documentation the resident complained of pain to her ankle until 11/08/17, and she was seen by the physician on 11/09/17. The physician ordered an x-ray which was done on 11/09/17, which identified an ankle fracture.

Lori Bentzler, Administrator
April 10, 2019
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The resident's record did not include documentation of any complaints of pain to her ankle prior to when it was identified. The assessment documented there was no bruising to the ankle/foot.

The physician's progress note documented "Left ankle pain . . . She has reported pain and swelling in the left ankle . . . the pain started on 11/8/17. She describes it as a stiff ankle with a throbbing sensation . . . There is some swelling but no bruising or obvious deformity of the left ankle. She is able to actively flex and extend ankle, but verbalizes pain when doing so." A subsequent physician progress note documented "what is certain is that she has osteoporosis . . . this places her at high risk for pathological fractures . . . it is probably osteoporotic related and unavoidable."

A written statement by the Physical Therapist (PT), stated the resident only worked with the PT one time the previous month, and the therapist had not observed the resident bump her foot or hit anything during therapy.

A written statement by the Certified Occupational Therapy Assistant (COTA), documented the resident worked with occupational therapy three times and the resident was not observed to bump or hit her foot/ankle on anything during her therapy.

Based on investigative findings the allegation was not substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

Two of the allegations were substantiated, but not cited. Therefore, 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,



Laura Thompson, RN, Supervisor
Long Term Care Progra

Lori Bentzler, Administrator
April 10, 2019
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June 18, 2019

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

Provider #: 135104

Dear Ms. Bentzler:

On **September 24, 2018** through **September 28, 2018**, an unannounced on-site complaint survey was conducted at Twin Falls Center. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007917

FINDINGS #1:

The facility did not investigate an allegation of potential abuse.

FINDINGS #1:

The records of 12 residents were reviewed. Grievance files, Incident and Accident (I&A) reports, Resident Council minutes, and Abuse/Neglect allegation investigations, as well as nursing schedules and daily assignments for several months were also reviewed. Interviews were conducted with ten residents, four family members, several nurses and Certified Nursing Assistants (CNAs), the social worker, the Director of Nursing Services (DNS), and the Administrator. Two hospice nurses and two hospice social workers were also interviewed. The facility staff were observed as they interacted with and responded to residents' needs in general and several CNAs and nurses were observed as they provided direct care for seven residents.

Lori Bentzler, Administrator
June 18, 2019
Page 2 of 7

The record for one resident documented care conferences were conducted almost every two weeks with family members, facility staff, and hospice staff present. Several facility staff and the hospice nurses and social workers stated they attended many of the care conferences. The facility staff and the hospice nurses and social workers said they did not recall ever hearing a family member say the resident appeared to be afraid of a facility staff member.

There were no documented reports or complaints of verbal, physical, or mental abuse found in the facility's Grievance files or Resident Council Minutes.

An investigation of allegations of neglect documented two residents were found "soaking wet" and in soiled incontinence briefs and bedding shortly after the change of shift one morning. The investigation included staff interviews which documented five residents, in total, were neglected and did not receive appropriate care. There was no evidence the allegations regarding the other three residents were investigated.

Interviews with the nursing staff, DNS, and Administrator confirmed the allegations were not investigated for the other three residents.

Based on the investigative findings, it was determined the facility failed to ensure allegations of abuse and neglect were investigated. The allegation was substantiated and the deficient practice was cited at F610.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #2:

The facility did not appropriately manage and monitor resident medications.

FINDINGS #2:

The records of 12 residents were reviewed. Grievance files, Incident and Accident (I&A) reports, Resident Council minutes, and investigations of allegations of Abuse/Neglect for several months were also reviewed. Interviews were conducted with ten residents, four family members, several facility nurses, and two hospice agency nurses.

All residents interviewed said they did not have concerns about their medications or the facility's management of their medications.

There were no documented concerns or complaints in the Grievance files, I&A reports, Resident Council Minutes, or Abuse/Neglect investigations regarding problems about medications or residents being over medicated.

One resident's record documented he was on "supratherapeutic doses (###)" of antidepressants and antipsychotic medications. The record documented his representative was resistant to decreasing these medications without consulting his neurologist in another state and the representative "insisted" he be awakened and given the medications. Two days after the out-of-state neurologist decreased the dose of the antipsychotic medication he exhibited worsening physical aggressive behavior toward staff, entered other residents' rooms, and he was hard to redirect. The worsened behavior was reported to the hospice agency and the hospice physician ordered Haldol, which was administered. The record documented a family member was contacted by telephone and two facility nurses obtained verbal consent for the use of Haldol.

Two facility nurses stated a family member verbally consented to the use of the Haldol. However, the family member said she did not consent to the use of Haldol and his representative was the one who authorized all of his medications. The resident representative said she did not consent to Haldol either and she was not aware of the Haldol until two days after the facility administered it to her loved one.

Based on the investigative findings, the facility did not obtain consent prior to administration of an antipsychotic medication. The allegation was substantiated and the deficient practice was cited at F758.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #3:

The facility did not make efforts to resolve grievances.

FINDINGS #3:

The records of 12 residents were reviewed. Grievance files, Incident and Accident (I&A) reports, Resident Council minutes, and Abuse/Neglect allegation investigations were also reviewed. Interviews were conducted with ten residents, four family members, several nurses and Certified Nursing Assistants (CNAs), a social worker, the Director of Nursing Services (DNS), and the Administrator. The facility staff were observed as they interacted with and responded to residents' needs and requests in general and several CNAs and nurses were observed as they provided direct care for seven residents.

One resident's record documented he was on a regular liberalized diet and family provided cereal, snacks, and his favorite drink. The record also documented one day after admission a request was made for no seeds, fruit with seeds, citrus fruits, grains, fish, or legumes. His meal, snack, and fluid intake records did not document the specific food items and liquids he consumed. His record also contained a list of his belongings, including underwear, shorts, and a blanket.

One Grievance documented a concern that a resident was not being offered cereal and snacks provided by the family. The facility promptly addressed the concern and conducted staff education and a care conference the next day. There were no other grievances that food and drink preferences were not honored. Grievances for several residents documented missing clothing items that were either found or replaced. All of the Grievances documented the facility responded quickly and addressed concerns and complaints promptly.

All of the residents interviewed said the staff acted quickly and were prompt in resolving their concerns and complaints. All of the staff interviewed said they took resident and family concerns seriously and addressed them right away.

Based on the investigative findings, the facility addressed and responded to known grievances and there was insufficient evidence to substantiate the allegation.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

The facility did not have sufficient nursing staff.

FINDINGS #4:

The Grievance files, Incident and Accident (I&A) reports, Resident Council minutes, and Abuse/Neglect allegation investigations for several months were reviewed, as were nursing staffing records, including schedules, daily assignments, and posted nurse staffing information. Interviews were conducted with ten residents, four family members, several nurses and Certified Nursing Assistants (CNAs), a social worker, the Director of Nursing Services (DNS), and the Administrator. The staff were observed as they interacted with and responded to residents' needs and requests in general and several CNAs and nurses were observed as they provided direct care for seven residents.

The residents and staff said the nursing staff was adequate on all shifts, weekends, and holidays. The residents did not voice concerns about inadequate staffing. The staff said unit managers helped out when needed and other staff would come in when nurses and CNAs called in.

There were no documented reports or complaints regarding inadequate staffing in Grievances files or Resident Council minutes.

Based on the investigative findings, inadequate staffing was not identified and there was insufficient evidence to substantiate the allegation.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #5:

The facility did not honor a resident's food and drink preferences.

FINDINGS #5:

The records of 12 residents were reviewed. Grievances and Resident Council minutes for several months were also reviewed. Interviews were conducted with ten residents, four family members, several nurses and Certified Nursing Assistants (CNAs), and 3 dietary staff. Four meal services and two snack times were observed during the survey.

One resident's clinical record documented he was on a regular liberalized diet and his family provided cereal, snacks, and his favorite drink. The record also documented one day after admission a request was made for no seeds, fruit with seeds, citrus fruits, grains, fish, or legumes. His meal, snack, and fluid intake records did not document the specific food items and liquids he consumed. While his weight fluctuated a few pounds, he did not have significant weight changes.

A Grievance/Concern form documented concerns that a resident was not being offered family provided cereal and snacks. The facility addressed the concern and conducted staff education and a care conference the next day. There were no other grievances that food and drink preferences were not honored.

During the meal services and snack time observations, the residents' food and drink preferences were honored. The residents interviewed said they did not have concerns about their food and drink preferences. The staff interviewed said they tried to accommodate residents' food and drink preferences and choices.

Lori Bentzler, Administrator
June 18, 2019
Page 6 of 7

The facility acted upon a concern that a resident's food and drink preferences were not being honored.

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

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #6:

The facility did not provide adequate supervision.

FINDINGS #6:

The records of 12 residents were reviewed. Grievance files, Incident and Accident (I&A) reports, Resident Council minutes, and Abuse/Neglect allegation investigations for several months were reviewed, as were nursing staffing records. Interviews were conducted with ten residents, four family members, several nurses and Certified Nursing Assistants (CNAs), and the Regional Resource Nurse Manager (RRNM). The staff were observed as they interacted with and responded to residents' needs and requests in general and several CNAs and nurses were observed as they provided direct care for seven residents.

I&A reports and one resident's clinical record documented he fell 20 times in just over 3 months and several of the falls resulted in minor injuries. His care plan was revised with interventions that included 15 minutes checks by staff were added after the 6th fall and after the 15th fall, the he was to be checked every 15 minute when he was in bed with one-to-one staff supervision when he was out of bed. His record documented the 15 minute checks and one-to-one staff supervision were not consistently implemented.

The RRNM said the every 15 minute checks and one-to-one staff supervision for one resident were not consistently implemented.

Based on the investigative findings, the facility did not provide adequate supervision. The allegation was substantiated and the deficient practice was cited at F689.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

Lori Bentzler, Administrator
June 18, 2019
Page 7 of 7

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,

A handwritten signature in black ink, appearing to read "Laura Thompson", is written over a light gray circular stamp.

Laura Thompson, RN, Supervisor
Long Term Care Program

LT/lj



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HEALTH & WELFARE

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June 19, 2019

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

Provider #: 135104

Dear Ms. Bentzler:

On **September 24, 2018** through **September 28, 2018**, an unannounced on-site complaint survey was conducted at Twin Falls Center. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007931

ALLEGATION#1:

The facility failed to investigate allegations of physical abuse.

FINDINGS #1:

Interviews were conducted with 10 residents, two family members, and staff members. Observations were conducted throughout the facility, including observations on the night shift.

The facility had completed an investigation related to an allegation of a staff member talking about spitting in a resident's food. The investigation documented the resident had asked the staff member what she had done to her food and the staff member had replied I spit in it. The staff member was interviewed and stated the resident liked to joke with her and when she said she spit in the resident's food it was a joke. In the investigation the resident was interviewed and stated she and the staff member were joking.

Lori Bentzler, Administrator
June 19, 2019
Page 2 of 4

A Neglect Allegation Summary, undated, included an allegation of neglect by a CNA. The summary stated two residents were found by a staff member soaking wet and one of the residents also had dried BM on her. The staff member stated it appeared they were not changed for several hours.

The Neglect Allegation Summary was incomplete. It did not include documented evidence the staff who witnessed the neglect and were aware of the suspected neglect were interviewed or gave a statement about the potential neglect.

The allegation was substantiated and the facility was cited with deficient practice at F610 for not investigating an allegation of abuse and/or neglect.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #2:

The facility failed to ensure investigations for missing resident property were conducted.

FINDINGS #2:

Interviews were conducted with 10 residents, two family members, and staff members. Observations were conducted throughout the facility, including observations on the night shift.

During an interview, the social worker stated she had been aware the resident's dentures were missing and already made an appointment for the dentures to be replaced. She stated she had told the resident of the appointment and the facility would pay for the replacement dentures but had not documented any of this in the resident's clinical record.

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

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The facility failed to respond to a resident's change of condition and send them to the hospital for an evaluation.

FINDINGS #3:

Interviews were conducted with 10 residents, two family members, and staff members. Observations were conducted throughout the facility, including observations on the night shift. The records of 12 residents were reviewed.

One resident's record documented they went to the hospital for evaluation. An RN was interviewed, who worked the night the resident went to the hospital, and she stated she did not have a chance to speak with the family. She stated the family was calling 911 when they approached her. The RN stated she had assessed the resident and the resident's vital signs and blood sugar were stable. She had administered Tylenol to the resident prior to the family calling 911.

The hospital history and physical for the resident did not include a diagnosis of dehydration and did not include documentation the resident would have died if she had not been sent to the hospital. The resident did have a urinary tract infection and was positive for an infection of the gastrointestinal tract (*C. difficile*). There was no documentation in the hospital history and physical related to a new open area. The Hospital H & P indicated the resident had a wound to her heel; the resident had been seeing a foot doctor while at the facility for this wound.

The resident's record included a physician order for an antibiotic for a urinary tract infection; however, when the physician assessed the resident three days later, it was documented a urine culture was not able to be completed and the physician discontinued the antibiotic the same day. The record also included documentation two stool samples were sent out and were negative for *C. difficile* and the physician was aware of the resident having loose stools. The resident had been to the foot doctor the day before going to the hospital.

Based on the investigative findings the allegation could not be substantiated. However, related deficiencies were cited at F600 for failing to ensure residents received the necessary care and services to prevent neglect and at F684 for the facility's failure to ensure care and services were provided as ordered.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

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

Lori Bentzler, Administrator
June 19, 2019
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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 printed name.

Laura Thompson, RN, Supervisor
Long Term Care Program

LT/lj