IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE– Governor
DAVE JEPPESEN– Director

TAMARA PRISOCK—ADMINISTRATOR
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BUREAU OF FACILITY STANDARDS
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P.O. Box 83720
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March 6, 2019

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

Provider #: 135136

Dear Mr. Gannon:

On **February 14, 2019**, we conducted an on-site revisit and a complaint investigation to verify that your facility had achieved and maintained compliance. We presumed, based on your allegation of compliance, that your facility was in substantial compliance as of **January 15, 2019**. However, based on our on-site revisit we found that your facility is not in substantial compliance with the following participation requirements:

- **F880 -- S/S: F -- 483.80(a)(1)(2)(4)(e)(f) -- Infection Prevention & Control**
- **F583 -- S/S: D -- 483.10(h)(1)-(3)(i)(ii) -- Personal Privacy/confidentiality Of Records**
- **F755 -- S/S: D -- 483.45(a)(b)(1)-(3) -- Pharmacy Srvcs/procedures/pharmacist/records**
- **F760 -- S/S: D -- 483.45(f)(2) -- Residents Are Free Of Significant Med Errors**

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.) **Please provide ONLY ONE completion date for each federal and state tag (if applicable) in column (X5) Completion Date** to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.
After each deficiency has been answered and dated, the administrator should sign the Form CMS-2567 and State Form (if applicable), Statement of Deficiencies and Plan of Correction in the spaces provided and return the original(s) to this office.
Your Plan of Correction (PoC) for the deficiencies must be submitted by **March 18, 2019**.

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.

- 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*.

As noted in the Bureau of Facility Standards' letter of **December 14, 2018**, following the survey of **November 30, 2018**, we have already made the recommendation to the Centers for Medicare and Medicaid Services (CMS) for a civil money penalty, Denial of Payment for New Admissions effective **03/01/2019** and termination of the provider agreement on **May 30, 2019**, if substantial compliance is not achieved by that time.

The findings of non-compliance on **February 14, 2019**, has resulted in a continuance of the remedy(ies) previously mentioned to you by the CMS. On **February 21, 2019**, CMS notified the facility of the intent to impose the following remedies:

- DPNA made on or after **March 7, 2019**

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, it will provide you with a separate formal notification of that determination.

If you believe the deficiencies have been corrected, you may contact please 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.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You may also contest scope and severity assessments for deficiencies, which resulted in a finding of SQC or immediate jeopardy. 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

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 **March 18, 2019**. If your request for informal dispute resolution is received after **March 18, 2019**, 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135136		R 02/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
QUINN MEADOWS REHABILITATION AND CARE CENTER	1033 WEST QUINN ROAD POCATELLO, ID 83202

(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	{F 000}		
	The following deficiencies were cited during an unannounced federal recertification revisit and complaint investigation survey conducted at the facility from February 12, 2019 through February 14, 2019. The surveyors conducting the survey were: Linda Kelly, RN, Team Coordinator Karen George, RN Survey Abbreviations: CNA = Certified Nursing Assistant DON = Director of Nursing gm = gram(s) H&P = History & P IM = Deep Muscle injection (Intramuscular) LPN = Licensed Practical Nurse mg = milligram(s) RN = Registered Nurse UTI = Urinary Tract Infection			
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the	F 583		3/8/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/11/2019

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 583	Continued From page 1 right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on staff interviews and review of facility cell phone text messages, clinical records, policies, and information in the facility's admission packet, it was determined the facility failed to ensure residents' personal health information remained secure and confidential. This was true for 2 residents (#142 and #143) whose personal health information was disseminated to and from physicians and facility staff, including the van driver, via unencrypted cell phone text messaging. The deficient practice created the potential for residents' to experience psychosocial harm when their personal health information was disseminated in a way that did not protect their confidentiality and health information. Findings include:	F 583	F583 Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) Corrective The smart phone has been removed from the nurses station and any identifiable resident information has been removed from that phone and the phone of the Executive Assistant Administrator; Identification All residents in the facility have the potential to be affected Measure All staff given an in-service education regarding HIPPA compliance and the	

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F 583	Continued From page 2 On 2/13/19 at 6:30 PM, the DON said nurses used a facility cell phone to call or text physicians and the facility's van driver about residents. She said if text messaging was used, the staff would give the resident's room number, not their name, and sometimes "minimal descriptors" of the resident, if needed. The DON said the facility's IT (Information Technology) provider had encrypted the facility cell phone and the nurses had to enter a code in order to use the cell phone. On 2/14/19 at 1:35 PM, the IT provider identified himself as the facility's contracted Services Provider. He said his company managed only the "hard line" telephones in the facility and were not involved in the set-up or management of any facility cell phones. The IT provider said for encryption to work, both the sender and receiver would need to have encryption capability on their cell phones. On 2/14/19 at 1:40 PM, the Administrator said he did not know if the facility cell phone was encrypted or not. The Regional Nurse was also present and said she was not aware the facility had a cell phone at the nurses' station. On 2/14/19 at 1:43 PM, the Regional Nurse accompanied 2 surveyors to the nurses' station where she asked RN #2 to explain use of the facility cell phone. RN #2 said she had been using the facility cell phone for 2 years to text doctors, other staff, and the transport driver. RN #2 said the facility cell phone was kept at the nurses' station and the nurses used residents' room numbers, not their names, when texting. RN #2 then picked up a cell phone, which had been in plain site on the counter, entered a code	F 583	updated facility process regarding contacting physicians, other health care providers and/or communicating with each other when protected resident health information is involved. Monitoring A random audit of 3 staff communication with physicians, other healthcare professionals and/or with other staff to ensure proper facility protocol is followed with no violations of HIPPA as well upholding resident rights to privacy/dignity. Monitoring will be done weekly x 4 weeks then every other week x 4 weeks then monthly x 3 months by Administrator or Designee starting on 3/15/2019;	

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F 583	Continued From page 3 into the cell phone, then opened the text messaging program in the cell phone. There were dozens of text messages referencing resident room numbers, pick up, and/or anticipated admission times. Among the dozens of text messages were 2 text messages with personal medical information as follows: * 2/4/19 - The Executive Assistant Administrator (EAA) texted: "admit coming," a room number (for Resident #143), a tentative pick up time of 2 PM, and, "We are not taking her until she voids." * 2/7/19 - A room number (for Resident #142), and instructions to do a thorough assessment of her hair to ensure she was "free of lice." On 2/14/19 at 1:55 PM, the Administrator said he knew nothing about encryption and to his knowledge, the facility cell phone was not encrypted. On 2/14/19 at 3:20 PM, the Administrator said he would see if he could obtain a print out of the facility cell phone text messages since 2/1/19 and he would look for a P&P, protocol, and/or guideline related to use of the facility cell phone. On 2/14/19 at 3:40 PM, the Regional Nurse said that facility cell phone use was "probably not" included in new nursing staff orientation and information about the cell phone would "all be verbal," including the code to open the phone. The Regional Nurse provided a Physician Services policy, revised in June 2004, and said it was all she could find and there was nothing specific about communication between the staff and physicians. She said the facility did not have	F 583		

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F 583	Continued From page 4 a policy regarding disseminating resident information via cell phone text messages. On 2/14/19 at 4:50 PM, the Administrator said there were 2 facility cell phones, including the one at the nurses' station and a flip phone at the EAA's desk. On 2/14/19 at 5:00 PM, the EAA said she received new resident intake information and used her personal cell phone to "group text" facility staff about new residents. The EAA said group text messages went to all department heads, administrative staff, the facility cell phone at the nurses' station, and the facility van driver. When asked about the facility flip cell phone, the EAA picked up a flip cell phone off her desk and said she did not use the flip cell phone for texting. She said she did not "even know how to text" using the flip cell phone. On 2/15/19 at 12:05 PM, the facility's Medical Director said he was in the facility 4 to 5 times a week, and when he was needed other times, the administrative staff and nurses would call him or text his personal phone. He said the EAA also would text new resident information to him and sometimes the nurses would text him if a resident's blood sugar was high or other laboratory test results were abnormal. He said a code was required to open his personal cell phone. He said he was "not familiar" with cell phone encryption, but no one else used his cell phone. He said the facility staff used residents' room numbers when they texted him about a resident. He said he received an updated resident census list with residents' names and room numbers everytime he went to the facility	F 583		

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F 583	Continued From page 5 and he had "memorized" his residents' room numbers. He said there had not been any problems with residents changing rooms and to his knowledge that had not happened. The facility's admission packet included the document A Matter of Rights - A guide to your Rights and Responsibilities as a Resident, updated 12/13/18, which documented, "...You have the right to: ...Confidentiality for your personal and health information..." The facility's Confidentiality and Non-Disclosure Agreement policy, revised in April 2006, documented the purpose of the policy was to maintain an "adequate level of security" to protect resident and facility information from unauthorized access, use or disclosure. It documented only authorized users were granted access to resident and facility information and was "limited to specific, defined, documented and approved applications and level of access rights."	F 583		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving,	F 755		3/8/19

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F 755	Continued From page 6 dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on review of medication error reports, clinical records, policy, and staff interview, it was determined the facility failed to ensure pharmacy services were provided to meet the needs of each resident. This was true for 2 of 8 residents (#84 and #135) whose medications were reviewed. The failure created the potential for harm when Resident #135's antiplatelet medication was not provided for 2 days and the first dose of Resident #84's antibiotic was not provided for 14 hours. Findings include: The Pharmaceutical Services policy, revised in 2001, documented "All medications, whether prescribed on a routine, emergency, or as needed basis, shall be provided in a timely manner."	F 755	F755 Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) Corrective Both resident #135 and #84 have discharged from the facility. Identification Any new residents admitted to the facility have the potential to be affected. Measure All licensed nursing staff given an in-service education to ensure updated first dosing protocol is followed for all new residents admitted to the facility.	

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F 755	Continued From page 7 The Emergency Pharmacy Service policy, revised in 2001, documented, "Pharmacy services shall be available to residents on a twenty-four (24)-hour basis." It documented telephone numbers of primary pharmacies were listed at the nurses' station and emergency medication dosing was the responsibility of the selected primary pharmacy. It also documented if a medication was not available in the emergency drug kit, or if the normal pharmacy supplier was not available, the charge nurse must call the emergency pharmacy number to obtain the medication. 1. Resident #135 was admitted to the facility on 10/29/18, with diagnoses including acute and chronic congestive heart failure and status post surgical placement of two cardiac (heart) stents. On 2/13/19 at 10:10 AM, the Regional Nurse stated the facility had used the hospital H&P as the facility admission orders for Resident #135. The H&P documented an order for Brilinta (prevents platelets from sticking together to form an unwanted blood clot that could block an artery) 90 mg by mouth twice a day, to start with the evening dose on 10/29/18. Resident #135's October 2018 MAR documented the facility did not administer the first dose of Brilinta on 10/29/18 at 8:00 PM or either dose on 10/30/18 at 8:00 AM and 8:00 PM; and, the medication was held on 10/31/18 at 8:00 AM. A 10/31/18 Progress Note, documented the Brilinta was held on 10/31/18 at 8:00 AM because Resident #135's family reported they	F 755	Monitoring A random audit of 3 new admission resident records to ensure first dosing of medications was done in a timely manner and if not, that licensed nursing staff followed proper facility protocol to obtain the medication. Monitoring will be done weekly x 4 weeks then every other week x 4 weeks then monthly x 3 months by Director of Nursing or Designee starting on 3/15/2019;	

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F 755	Continued From page 8	F 755		

had given him a dose of Brilinta at 3:00 AM that morning while he was in an emergency department.

On 2/13/19 at 10:45 AM, the Administrator and the DON stated the facility had been having problems getting medications from the pharmacy services provider in a timely manner. The Administrator stated Brilinta was not available from the pharmacy services provider or any of their local satellite pharmacies on 10/29/18 and they notified him the Brilinta would be delivered to the facility on 10/31/19 at 3:44 AM. The Administrator stated the facility identified the problem, and on 11/1/18 the facility contracted with a local 24 hour pharmacy for first dose medications not available in a timely manner from the pharmacy services provider.

Later in the morning on 2/13/19, the DON provided a pharmacy medication delivery record which documented Resident #135's Brilinta was delivered to the facility on 10/31/18 at 3:44 AM.

2. Resident #84 was admitted to the facility on 11/13/18 with multiple diagnoses including diverticulitis of the intestine with perforation and abscess.

On 11/19/18, her physician ordered Rocephin 1 gm IM once a day for UTI. A clarification order, dated 11/20/18, documented the Rocephin was to be administered once a day for 3 days.

A medication error report documented Resident #84's Rocephin, ordered on 11/19/18, did not get started for 14 hours.

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F 755	Continued From page 9 The DON's 11/21/18 analysis of the 11/19/18 medication error documented the pharmacy failed to send the first dose of the antibiotic. The DON documented the actions taken to prevent recurrence included a conversation with the pharmacy account manager to always send the first dose of an antibiotic when they receive the order. Resident #84's MAR for November 2018 documented the Rocephin was administered at 11:00 AM on 11/20/18, 11/21/18, and 11/22/18. On 2/12/19 at 5:10 PM, the DON said Resident #84's Rocephin was administered late when the pharmacy services provider did not provide the first dose of the medication in a timely manner.	F 755		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure physician ordered medications were administered in a timely manner for 2 of 3 residents (#84 and #135) reviewed for medication errors. Failure to administer Resident #135's antiplatelet medication for 2 days increased his risk for blood clots to develop and adverse outcome; and failure to administer Resident #142's antibiotic for 14 hours increased her risk for worsening infection. Findings include: 1. Resident #135 was admitted to the facility on	F 760	F760 Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) Corrective Both resident #135 and #84 have discharged from the facility. Identification All residents in the facility have the potential to be affected. Measure	3/8/19

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	135136		R 02/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
QUINN MEADOWS REHABILITATION AND CARE CENTER	1033 WEST QUINN ROAD POCATELLO, ID 83202

(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 760	Continued From page 10 10/29/18 with multiple cardiac (heart) disease diagnoses, including acute and chronic congestive heart failure, ischemic (deficient blood supply) cardiomyopathy (enlarged heart), atherosclerotic heart disease, history of pulmonary embolism and cardiogenic shock, and recent cardiac stent and pacemaker placement. On 2/13/19 at 10:10 AM, the Regional Nurse stated the facility used the H&P from the hospital as the facility admission orders for Resident #135. This H&P documented an order for Brilinta (an antiplatelet medication) 90 mg by mouth twice a day, beginning on 10/29/18 with the evening dose. A progress note, dated 10/29/18 at 4:20 PM, documented the Brilinta was to be given twice a day and the first dose should be at 8:00 PM. Resident #135's October 2018 MAR documented the Brilinta was not administered three times: 10/29/19 at 8:00 PM, and on 10/30/19 at 8:00 AM and 8:00 PM. On 02/13/19, the DON provided a pharmacy prescription delivery record which documented the Brilinta was delivered to the facility on 10/31/18 at 3:44 AM. On 10/31/19 the 8:00 AM, administration of Brilinta was held because the facility was notified by Resident #135's family a dose of the medication was given to Resident #135 while he was out of the facility at 3:00 AM in the emergency department. Resident #135's missed doses of Brilinta increased his risk of developing blood clots, which could result in increased risk	F 760	An in-service education was given to all licensed nursing staff regarding the updated facility protocol if a new admission medication is not available or not first dosed by the pharmacy. Monitoring A random audit of 3 new admission resident records to ensure first dosing of medications was done in a timely manner and if not, that licensed nursing staff followed proper facility protocol to obtain the medication. Monitoring will be done weekly x 4 weeks then every other week x 4 weeks then monthly x 3 months by Director of Nursing or Designee starting on 3/15/2019;	

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F 760	Continued From page 11 for pulmonary embolism, stroke, or heart attack. On 02/14/19 at 11:02 AM, a family member of Resident #135 stated on 10/30/18 she was very concerned about Resident #135 not receiving the ordered Brilinta the night before, or the morning of 10/30/18. She stated she then called the cardiac physician and obtained a prescription for Brilinta. After retrieving the medication from a local pharmacy, she gave a dose of Brilinta to Resident #135 prior to taking him to the emergency department for an evaluation and gave him an additional dose while he was in the emergency department. The family member stated she was insistent Resident #135 be seen at the emergency department because the facility had not administered the medication and she didn't feel Resident #135 was doing well. The family member stated, "He just didn't look good." After returning from the emergency department she stated she told the facility they should hold the morning dose of Brilinta because Resident #135 received a dose at 3:00 AM. According to the MAR, three doses were missed and one was held because Resident #135's wife reported administering the dose at 3:00 AM. Resident #135's wife also administered a dose on the evening of 10/30/19. The missed dose count was only two doses of the medication which could have led to adverse consequences for Resident #135. During an interview, on 02/13/19 at 10:45 AM, the Administrator and the DON stated the facility had been having difficulty with the pharmacy. The facility identified this problem, with this resident and others, and acted by entering into a contract with another local pharmacy. This new contract	F 760		

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F 760	Continued From page 12 was effective 11/01/18. 2. Resident #84 was admitted to the facility on 11/13/18 with multiple diagnoses including diverticulitis of the intestine with perforation and abscess. On 11/19/18 at 8:25 PM, Resident #84's physician ordered Rocephin (an antibiotic) 1 gm IM once a day for UTI. A clarification order dated 11/20/18, documented the IM Rocephin was to be administered once a day for 3 days. Resident #84's November 2018 MAR documented the IM Rocephin was administered at 11:00 AM on 11/20/18, 11/21/18, and 11/22/18. A 11/20/18 medication error report documented "wrong date/time of administration" for Resident #84's Rocephin ordered on 11/19/18. It documented the Rocephin did not get started for 14 hours. On 11/21/19, the DON's investigation of this error documented the pharmacy failed to send the first dose of the Rocephin. Also, nursing staff had limited access to Pyxis (an automated medication dispensing system). The DON documented the actions taken to prevent recurrence were all nursing staff obtained access to the Pyxis, and she spoke with the Pharmacy Account Manager to have the pharmacy always send the first dose of an antibiotic when they received the order. On 2/12/19 at 5:10 PM, the DON said Resident #84's IM Rocephin, ordered on 11/19/18, was administered late because the pharmacy did not send the first dose of the medication and	F 760		

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F 760	Continued From page 13 because there was one nurse on duty on the evening of 11/19/18 and she was unable to access the Pyxis. The DON said the nurse's password to access the Pyxis had expired and the nurse did not call her to request assistance to access the Pyxis.	F 760		
{F 880} SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or	{F 880}		3/8/19

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{F 880}	Continued From page 14 infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:	{F 880}		

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{F 880}	Continued From page 15 Based on observation, interview, and policy review, the facility failed to ensure implementation of infection control practices for the operation of the laundry department, and the facility failed to ensure isolation precautions were implemented for 1 of 2 residents (#142) who was on isolation precautions. The staff did not wear proper personal protective equipment (PPE) when entering the room and providing care for Resident #142. Findings include: 1. On 2/14/19 at 10:35 AM, the laundry room was observed to have a wall dividing the clean side from the dirty side. Between the two sides was a large opening without doors. Both sides of the laundry room, down the center wall, had counter tops against the center wall with cupboards above the counters. At the far end of the counter on the dirty side, and against the outside wall of the laundry room, was the hand-wash sink. In front of the handwash sink, up against the counter top and in the corner of the outside wall sat a dirty laundry basket, which was large and about counter top high. This laundry basket blocked access to the front of the hand-wash sink. Up against the dirty laundry hamper and the counter top sat a clean laundry rolling basket. This basket was used for folded clean laundry, and to move laundry from the washers to the dryers, and from the dryers to the counter top for folding. The rolling laundry basket was also used to transport laundry to the resident rooms. A second dirty laundry basket sat immediately to the right after entering the dirty laundry side of the laundry room. This basket was up against the inside wall and positioned half on the dirty laundry side of the room and half on the clean laundry side of the room. To the immediate left,	{F 880}	F880 Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) Corrective -An updated process has been implemented to ensure infection control practices for the laundry department operation; -Resident #142 was removed from isolation precautions. Identification -All residents in the facility that utilize facility laundry services have the potential to be affected; -All residents in the facility have the potential to be affected regarding the isolation precautions. Measure - An updated process for the laundry department has been implemented which includes the following: *Signs are posted on the counter of the □dirty□ side of the laundry room to prevent sorting or folding of clean laundry on that counter. All clean laundry sorting and folding to take place on the counter on the □clean□ side; *The □clean□ laundry cart had been labeled and is stored on the □clean□ side of the laundry room; *The storage shelves on the □clean□ side of the laundry room have been covered to protect the items on the shelves; * The door on the □clean□ side of the laundry room has been labeled on both sides for clean laundry exit only;	

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{F 880}	Continued From page 16 after entering the dirty side of the laundry room was located an industrial washer. Next to, and up against the industrial washer, was an industrial dryer, followed by a smaller washer, and then a smaller dryer. These washers and dryers took up the length of the wall immediately to the left after entering the door on the dirty side of the laundry room. Laundry Staff #1 was observed folding clean laundry on the dirty side of the laundry room and using the rolling laundry basket and the dirty side counter top to process clothing items. The counter top on the clean side of the laundry room was covered with already folded items. The storage shelves on the clean side of the laundry room, against the far-right wall, were filled with assorted linens. The shelves did not have doors or coverings to protect the items, and the items were open to the air in the room. On 2/14/19 at 10:35 AM, the Director of Environmental Services stated the laundry was usually folded on the dirty side of the laundry room. She stated when dirty laundry bins were retrieved from the resident units, they were brought into the dirty laundry side of the room. The bins brought into the room were placed next to the industrial washer and dryer, and the dirty laundry was sorted into the two baskets located on either end of the dirty laundry side of the room. The staff did not move the dirty laundry baskets closer to the bins that were rolled into the room. They sorted the dirty laundry into one or the other dirty laundry basket at either end of the dirty laundry side of the room. This practice caused the dirty laundry to be moved throughout the dirty laundry side of the laundry room and alongside the dirty laundry counter top, where staff folded clean laundry, and over the rolling	{F 880}	*The □dirty□ laundry bins will be replaced with new ones that fit under the counter on the □dirty□ side of the laundry room. The new bins have been ordered and will arrive in about a week. Each of those carts will be labeled for proper placement of soiled/isolation laundry; *The door on the □dirty□ side of the laundry room has been labeled for soiled laundry entry only; -All laundry staff in-serviced regarding the updated process for laundry department to ensure infection control practices; -1:1 counseling education was given to the C.N.A that did not follow proper isolation precautions; -An in-service education given to all licensed nurses regarding the proper protocol and necessary documentation needed for placing a resident on isolation precautions; -All staff have participated in a skills check regarding the proper use of isolation precaution personal protective equipment to ensure all staff know the proper protocol and process for using PPE for entering residents rooms that are on isolation precautions; Monitoring -A random audit of laundry procedures to ensure updated process for laundry department operation is being followed; -A random audit of at least 3 residents on isolation precautions to ensure proper protocol is followed and proper documentation is in place to warrant isolation precautions;	

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{F 880}	Continued From page 17 basket used by staff to move clean laundry from the washers to the dryers, and from the dirty side counter top to the resident's rooms. Laundry Staff (LS) #1 stated the staff usually folded laundry on the dirty side of the laundry room because they didn't have enough space on the clean side of the laundry room. The Director of Environmental Services stated the facility had not identified these practices as problematic and stated mingling of dirty and clean laundry tasks, or the proximity of the washers and dryers in the dirty side of the laundry room as problematic. On 2/14/19 at 11:00 AM, LS #1 was observed to continue to fold clean laundry on the dirty side countertop of the laundry room, with the clean laundry rolling basket still sitting up against the dirty laundry basket located at the outside wall and corner of the dirty counter top and sink. LS #1 stated she consistently used the countertop on the dirty side of the laundry room to fold clean laundry. The facility's soiled laundry and bedding policy dated September 2005, did not address mingling of dirty and clean laundry. On 2/14/19 at 1:00 PM, the Administrator stated the facility had not identified the separation of soiled and clean laundry, in the laundry room, as an area for improvement. He stated, "It's been this way since the facility opened in 2009." On 2/14/19 at 3:00 PM, the Director of Nursing, who was also the Infection Preventionist, stated the set up in the laundry room had not been identified as problematic for infection prevention. She stated the facility did not identify the sorting	{F 880}	-A random visual audit of at least 3 staff to ensure proper following of facility protocol and proper use of PPE when entering residents□ rooms that are on isolation precautions. Monitoring will be done weekly x 4 weeks then every other week x 4 weeks then monthly x 3 months by Administrator or Designee starting on 3/15/2019;	

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{F 880}	Continued From page 18 of dirty laundry in the same area where clean laundry was being processed as problematic and did not identify the layout of the washers and dryers did not allow for separation of dirty laundry tasks and clean laundry tasks. 2. The facility's isolation policy, revised September 2005, documented, "Appropriate precautions shall be used either at all times (Standard Precautions) or for individuals who are documented or suspected to have infections or communicable diseases that can be transmitted to others (Transmission-Based Precautions)" and "...the facility shall use the term "Isolation Precautions" to refer to the overall approach to preventing transmission of communicable diseases." It documented isolation precautions included both standard precautions and transmission-based precautions. It documented transmission-based precautions included "Droplet Precautions" and an example of infections requiring droplet precautions included influenza. The policy also documented in addition to standard precautions, a mask should be worn when working within 3 feet of the resident. Resident #142 was readmitted to the facility on 2/7/19 with multiple diagnoses, including influenza A. Resident #142's 2/6/19 hospital Discharge Summary Note documented Resident #142 had Influenza A and was very slow to improve and likely had a significant viral pneumonia related to the influenza A, and Resident #142 was able to complete her Tamiflu (an antiviral medicine to treat influenza) regimen.	{F 880}		

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{F 880}	Continued From page 19 On 2/12/19 at 1:20 PM, an isolation cart with PPE (personal protective equipment, including gloves, isolation gowns and masks) was observed in the hallway by Resident #142's door and a sign directing visitors to check at the nurses' station before entering the room was posted on her open door. On 2/13/19 at 8:15 AM, the PPE cart was again observed by Resident #142's door and the sign directing visitors to the nurses' station before entering the room was still posted on her open door. On 2/13/19 at 8:17 AM, CNA #1 was observed as she entered Resident #142's room without putting on PPE. The CNA delivered and set-up a breakfast meal tray on an over bed table directly in front of Resident #142, who was sitting in a recliner by her bed. The CNA then left the room without performing hand hygiene. CNA #1 was stopped as she approached the meal cart in the hallway several rooms away from Resident #142's room. The CNA said she did not put on PPE before she entered Resident #142's room and she did not perform hand hygiene before she left Resident #142's room. CNA #1 said Resident #142 was in isolation for influenza A, but Resident #142 was on antibiotics. On 2/13/19 at 8:19 AM, LPN #2 arrived at the meal cart in the hallway and said she thought Resident #142 may be off isolation even though the PPE cart and sign for visitors to check at the nurses' station were both still in place. The LPN said Resident #142 had had Tamiflu and Tamiflu was usually effective within 7 days. CNA #1 was still present and she said Resident #142 chose to	{F 880}		

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{F 880}	Continued From page 20 eat in her room. CNA #1 then began to move the meal cart toward another hallway. On 2/13/19 at 8:20 AM, the DON was informed of the observation regarding CNA #1's failure to wear PPE or perform hand hygiene related to isolation precautions for Resident #142. The DON said Resident #142 had not been cleared to be off isolation precautions and she would stop CNA #1 from passing more meal trays. On 2/13/19 at 8:40 AM, the DON said there was no physician's order for Resident #142 to be on isolation precautions and she was placed in isolation on 2/7/19 per a facility nurse's nursing judgment. On 2/13/19 at 10:45 AM, the DON said she expected staff to wear PPE when going into Resident #142's room as long as the sign was posted and a PPE cart was in place. The DON then provided a 2/13/19 physician's order to discontinue isolation precautions for influenza A. On 2/14/19 at 9:20 AM, Resident #142 said she was not aware that she was on isolation precautions since her admission to the facility but it did not bother her because she preferred to stay in her room.	{F 880}		

IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

TAMARA PRISOCK—ADMINISTRATOR
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June 24, 2019

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

Provider #: 135136

Dear Mr. Gannon:

On **February 14, 2019**, an unannounced on-site complaint survey was conducted at Quinn Meadows Rehabilitation and Care Center. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00008001

ALLEGATION #1:

The facility failed to provide prescribed medications for a resident as ordered and keep residents free from medication errors.

FINDINGS #1:

An unannounced complaint survey was conducted in conjunction with a revisit survey on 2/12/19 through 2/14/19. Fourteen residents records were reviewed for medication orders and administration, pharmacy records were reviewed, staff were interviewed, and residents and family were interviewed.

One resident's record documented they were discharged from a hospital with orders for a blood thinning medication to be given twice a day. The resident's record documented they did not

receive four doses of the medication over a three day period.

A family member of the resident stated she was very concerned about them not receiving the ordered medication the night before, or the next morning. She stated she then called the cardiac physician and obtained a prescription for the medication and gave the resident a dose and took them to the Emergency Department. The family member stated she was insistent the resident be seen at the emergency department because the facility had not administered the medication and she didn't feel the resident was doing well.

The Administrator and Director of Nursing stated they had been having problems getting medications from the pharmacy in a timely manner.

CONCLUSIONS:

Based on investigative findings, the allegation was substantiated and deficiencies were cited at F755 and F760 related to the facility's failure to ensure pharmacy services were provided to meet the needs of the residents.

ALLEGATION #2:

The facility failed to ensure medical records were obtained for a resident's visit to an Emergency Department.

FINDINGS #2:

Fourteen resident records were reviewed.

One resident's record did not include the Emergency Department records after he went for an evaluation. The resident's record showed the facility had not gathered information from the Emergency Department when the resident was evaluated in 10/2018. The facility was able to gather the information during the survey to complete the record.

The facility had a past deficient practice for not having consistent and accurate information in resident's records and was cited at F842. The facility did not have a current deficient practice.

CONCLUSIONS:

Based on the investigative findings the allegation was substantiated, but no deficient practice was cited because the facility had corrected the practice per their plan of correction for the previous survey.

ALLEGATION #3:

The facility failed to ensure liquids were available to meet residents needs and preferences as related to hydration.

FINDINGS #3:

During the survey resident records were reviewed and observations were conducted.

One resident's record documented they were diagnosed as being dehydrated at the Emergency Department. The resident's record did not include documentation the facility was deficient in providing drinks to meet the resident's need.

Seven residents were reviewed for dehydration, including their records and intake of fluids. Observations were made during meal preparations, meals, and for residents waiting in the dining room to ensure liquids were available to residents. Residents were observed to have fluids available in the dining room prior to meals, during meals, and in their rooms.

CONCLUSIONS:

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

ALLEGATION #4:

The facility failed to ensure proper precautions were taken to ensure residents' records were not accessed by unauthorized individuals.

FINDINGS #4:

During the survey a family member was interviewed, the Resident Advocate was interviewed, the medical records clerk was interviewed, and resident records were reviewed.

A family member and the Resident Advocate were interviewed, and no specific information was offered supporting the receipt of other residents' medical documentation instead of what was requested.

The medical records clerk was interviewed regarding the provision and the documentation of the provision of medical records. There were no concerns identified. The investigation revealed no evidence incorrect medical records were provided regarding residents who were reviewed.

CONCLUSIONS:

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

ALLEGATION #5:

The facility failed to ensure appropriate medications were made available, and administered correctly, to residents.

FINDINGS #5:

During the survey 14 resident records were reviewed, family was interviewed, staff was interviewed, and observations of medication administration were conducted.

Two staff were called and stated they did not "borrow" or administer medications from one resident to another.

Fourteen sampled residents were reviewed for medication administration and there was no documentation of residents receiving the wrong medications or another resident's medications.

Medication administrations were observed and no concerns were identified that residents medications were not theirs or were the wrong medications.

The Director of Nursing was interviewed, who stated borrowing of medication was not allowed in the facility and the administration was not aware of any instances of this occurring.

CONCLUSIONS:

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

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

Thank you for the courtesies and assistance extended to us during our visit. Based on the findings of the investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. One of the allegations was substantiated, but not cited. No response is necessary to this findings letter, as it will be addressed in the provider's Plan of Correction.

If you have any questions, comments or concerns regarding this matter, please contact Laura

Thompson, RN, or Belinda Day, RN, Supervisors, Long Term Care Program at (208) 334-6626, Option #2.

Sincerely,

LAURA THOMPSON, RN, Supervisor
Long Term Care Program

LT/slj