



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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3232 Elder Street  
P.O. Box 83720  
Boise, Idaho 83720-0009  
PHONE: (208) 334-6626  
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May 8, 2019

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

Provider #: 135136

Dear Mr. Gannon:

On **April 24, 2019**, a survey was conducted at Quinn Meadows Rehabilitation and Care Center by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be an isolated deficiency that constitutes actual harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567 listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3.) **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 **May 20, 2019**. Failure to submit an acceptable PoC by **May 20, 2019**, may result in the imposition of civil monetary penalties by **June 10, 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; 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*.

We are recommending that Centers for Medicare & Medicaid Services (CMS) Region X impose the following remedy(ies):

- **Denial of payment for new admissions effective July 24, 2019**
- **A civil money penalty**

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We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **October 24, 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 Laura Thompson, RN or Belinda Day, RN, Supervisors LTC, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 2; 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.

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>

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

- BFS Letters (06/30/11)

[2001-10 Long Term Care Informal Dispute Resolution Process](#)  
[2001-10 IDR Request Form](#)

This request must be received by **May 20, 2019**. If your request for informal dispute resolution is received after **May 20, 2019**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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Thank you for the courtesies extended to us during the survey. If you have any questions, comments or concerns, please contact Belinda Day, RN, or Laura Thompson, RN, Supervisors, Long Term Care Program at (208) 334-6626, option #2.

Sincerely,

A handwritten signature in black ink, appearing to read "Laura Thompson".

Laura Thompson, RN, , Supervisor  
Long Term Care Program

LT/dr

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

PRINTED: 05/31/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135136</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/24/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>QUINN MEADOWS REHABILITATION AND CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1033 WEST QUINN ROAD</b> <b>POCATELLO, ID 83202</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS  The following deficiencies were cited during the complaint survey of the facility. The survey team entered the facility on April 22, 2019 and exited the facility on April 25, 2019.  The surveyors were:  Jenny Walker, RN, Team Leader Roxie Lacey, RN  Abbreviations:  Bipap = Bilevel Positive Airway Pressure CHF = Congestive Heart Failure cm = centimeter CNA = Certified Nursing Assistant COPD = Chronic Obstructive Pulmonary Disease DNS = Director of Nursing GERD = Gastro-Esophageal Reflux Disease LPN = Licensed Practical Nurse MAR = Medication Administration Record MDS = Minimum Data Set RN = Registered Nurse TAR = Treatment Administration Record	F 000			
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g)  §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility failed to ensure residents' MDS assessments accurately reflected their skin impairments. This was true for 1 of 8 residents (Resident #4) reviewed for MDS	F 641	F 641 Accuracy of Assessments CFR(s): 483.20(g)  Corrective Resident #4 is no longer a current	5/27/19	

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

TITLE

(X6) DATE

Electronically Signed

05/18/2019

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 641	<p>Continued From page 1</p> <p>accuracy. This deficient practice created the potential for harm if residents did not receive treatment for skin breakdown. Findings include:</p> <p>The National Pressure Ulcer Advisory Panel website (<a href="http://www.npuap.org">www.npuap.org</a>), accessed on 4/29/19, states a Stage 2 pressure injury may present as an intact or ruptured serum-filled blister. It also documents a Stage 3 pressure injury is a full-thickness skin loss, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present.</p> <p>Resident #4 was admitted to the facility on 12/6/18, with multiple diagnoses including a left femur fracture.</p> <p>A weekly skin assessment, dated 12/11/18, documented Resident #4 had a left heel blister.</p> <p>Resident #4's MDS assessments, dated 12/13/18, 12/20/18, 12/27/18, 1/3/19 and 1/31/19, documented he did not have unhealed pressure ulcers. The MDS completed on 2/15/19 documented he had one Stage 3 pressure ulcer.</p> <p>A weekly skin assessment, dated 12/11/18, documented Resident #4 had a left heel blister.</p> <p>A physician's order, dated 12/12/18, documented licensed staff were to apply skin prep (a liquid that when applied to the skin forms a protective film or barrier), apply a cushioned heel dressing, and secure with Kerlex (gauze) wrap every evening. Resident #4 was referred to a wound care clinic on 1/2/19.</p> <p>On 4/24/19 at 12:57 PM, the MDS Coordinator</p>	F 641	<p>resident in the facility.</p> <p>MDS for resident #4 has been modified with appropriate corrections.</p> <p><b>Identification</b> According to the CMS report 2567 this deficient practice was an isolated incident and no other residents were directly affected. However, all residents in the facility with skin issues have the potential to be affected. By 4/11/2019 the facility's new Skin Nurse performed a head-to-toe skin assessment for all current residents in the facility.</p> <p><b>Measure</b> By 5/27/2019 the MDS coordinator will receive a 1:1 in-service education regarding the importance of MDS assessments accurately reflecting skin impairments. Skin assessments for new admissions, weekly skin checks and other occurrences will be reviewed by the MDS coordinator prior to coding.</p> <p>The MDS Coordinator and facility Skin Nurse will review wound status of residents on a weekly basis to ensure wounds are coded correctly on scheduled MDS assessments and use the data to consider whether there is a need to complete a change of condition assessment.</p> <p>The facility Skin Nurse will assess and document status of resident wounds every week.</p>		

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F 641	Continued From page 2 stated she reviewed progress notes and asked the nurses if Resident #4 had a skin impairment when completing the MDS assessments. The MDS Coordinator stated Resident #4 had a wound and she did not document it on the MDS assessments.  On 4/24/19 at 4:15 PM, the DNS stated the MDS assessments were coded wrong for Resident #4's pressure ulcer to his left heel.	F 641	Monitoring The Director of Nursing or Licensed designee will perform a random audit of at least 4 MDS assessments to ensure skin impairments are accurately reflected and coded consistent with resident wound status.  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 6/3/2019.  MDS coding of resident wounds will be added to the facility QAPI agenda for review x 3 months.		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)  §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights	F 656		5/27/19	

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F 656	<p>Continued From page 3</p> <p>under §483.10, including the right to refuse treatment under §483.10(c)(6).</p> <p>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.</p> <p>(iv) In consultation with the resident and the resident's representative(s)-</p> <p>(A) The resident's goals for admission and desired outcomes.</p> <p>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.</p> <p>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, staff and resident interview, and record review, it was determined the facility failed to develop and implement comprehensive resident-centered care plans related to residents' respiratory and skin care needs. This was true for 2 of 8 residents (#1 and #3) whose care plans were reviewed. This failure created the potential for residents to receive inappropriate or inadequate care. Findings include:</p> <p>1. Resident #3 was admitted to the facility on 1/7/19, with multiple diagnoses including aftercare from hip surgery.</p>	F 656	<p>F 656 Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)</p> <p>Corrective Resident #1 and Resident #3 are no longer current residents in the facility.</p> <p>Identification According to the CMS report 2567 this deficient practice was isolated and no other residents were directly affected. However, all residents in the facility with respiratory or skin care needs have the</p>		

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F 656	Continued From page 4  Resident #3's skin integumentary care plan, dated 1/7/19, documented staff were to encourage Resident #3 to float his heels (elevate heels off the bed to prevent pressure on them). The care plan did not include how and when to float Resident #3's heels.  A Weekly Pressure Ulcer Skin Assessment, dated 1/16/19 at 12:47 PM, documented Resident #3 had an in-house acquired blister to his right heel. The National Pressure Ulcer Advisory Panel website (www.npuap.org), accessed on 4/29/19, states a Stage 2 pressure injury may also present as an intact or ruptured serum-filled blister.  On 4/24/19 at 3:30 PM, the DNS stated Resident #3's care plan did not include how and when the staff were to float Resident #3's heels prior to him developing the pressure ulcer.  2. Resident #1 was admitted to the facility on 1/28/19, and readmitted to the facility on 4/17/19, for multiple diagnoses including acute respiratory distress, COPD (progressive lung diseases characterized by increasing breathlessness), CHF, and sleep apnea.  On 4/22/19 at 3:15 PM, Resident #1 was observed in her room with a Bipap machine next to her bed. Resident #1 stated she had used the Bipap at bedtime for the past four years. Resident #1 stated she had used the Bipap at night since she was admitted to the facility on 1/28/19. Resident #1 stated she was in the hospital 4/15/19 to 4/17/19 for respiratory failure.	F 656	potential to be affected. By 5/27/2019 the Director of Nursing or licensed designee will perform a review of all residents with respiratory or skin care needs to ensure their care plans are developed to reflect resident-centered comprehensive interventions.  Measure By 5/27/2019 all licensed nurses will receive an in-service education regarding complete and accurate documentation on the care plan for all medications and treatments but specifically related to preventative skin care interventions and/or BIPAP/CPAP use, settings and scheduled cleaning.  New admissions are reviewed by the IDT at the morning meeting to ensure orders have been processed and care plans have been initiated for existing issues.  New orders are reviewed by IDT at morning meeting to ensure they have been added to resident record as indicated.  Monitoring  The Director of Nursing or Licensed designee will perform a random audit of at least 4 care plans to ensure skin care or respiratory needs are accurately reflected.  Monitoring will be done weekly x 4 weeks		

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F 656	Continued From page 5 Resident #1's care plan, initiated 3/30/19, documented she had a history of a sleep disorder, CHF, and COPD. The care plan interventions did not include the use of the Bipap machine, the settings of the Bipap machine, and when to clean the mask of the Bipap machine.  On 4/23/19 at 11:45 AM, the DNS stated the use of the Bipap machine, the settings of the Bipap, and when to clean the mask to the Bipap should have been on the care plan to direct staff on how to provide care to Resident #1.	F 656	then every other week x 4 weeks then monthly x 3 months by Director of Nursing or Designee starting on 6/3/2019.  Audit results will be added to the facility QAPI agenda for review x 3 months.		
F 684 SS=G	Quality of Care CFR(s): 483.25  § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interviews, review of Incident and Accident reports, and resident record review, it was determined the facility failed to ensure professional standards were followed for 2 of 8 residents (#1 and #2) who were reviewed for standards of practice. Resident #1 was harmed when diagnostic and medical treatment was delayed for 4 days after she experienced a fall resulting in a left ankle fracture. Resident #2 had the potential for harm when the facility failed to follow physician orders for medications. Findings	F 684	F 684 Quality of Care CFR(s): 483.25  Corrective Resident #1 and Resident #2 are no longer current residents in the facility.  Identification All current residents in the facility that experience an incident/accident or that have medication adjustments have the potential to be affected.	5/27/19	

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F 684	<p>Continued From page 6 include:</p> <p>1. Resident #1 was admitted to the facility on 1/28/19, for multiple diagnoses including COPD (progressive lung diseases characterized by increasing breathlessness).</p> <p>A 5-day MDS assessment, dated 4/24/19, documented Resident #1 was cognitively intact and required the assistance of one staff with bed mobility and transfers.</p> <p>Resident #1's admission physician's orders, dated 1/28/19, documented Apixaban (blood thinner) 5 mg twice a day, Prednisone 20 mg a day until 2/2/19, and Oxycodone 10-325 mg one tablet every 6 hours as needed for severe pain.</p> <p>An Incident and Accident report, dated 1/30/19 at 7:00 AM, documented Resident #1 had a fall while ambulating herself to the bathroom and received a skin tear to her left elbow and landed on her right knee. The report documented Resident #1 had a "possible twist" and the body diagram circled to the right lower extremity. The report documented Resident #1 stated she may have twisted her ankle. LPN #1 documented Resident #1 was able to move her ankle without pain, range of motion was within normal limits, and she had no bruising or swelling at the time of the incident. The report did not specify which ankle Resident #1 stated she twisted and what ankle was assessed by LPN #1.</p> <p>A Physician Annual Examination, dated 1/30/19, documented Resident #1 was transferred to the facility for rehabilitation care. The examination documented she had a left sprained ankle with</p>	F 684	<p><b>Measure</b> By 5/27/2019 all licensed nurses will receive an in-service education from the Director of Nursing or licensed designee about completing a thorough assessment and providing complete documentation for resident incident/accidents. With changes in resident condition, nurses will complete an assessment, document findings and relevant information including MD notification. Orders received will be processed and added to appropriate documents (TAR, Careplan, MAR).</p> <p>Alert charting, at minimum, x 3 days post following resident incident/accidents.</p> <p>By 5/27/2019 all licensed nurses will receive an in-service education from the Director of Nursing or licensed designee about reviewing physician orders and seeking clarification when changes to existing dose are made. Nurse will seek DC order for existing medication/dose, notify pharmacy and update orders in computer system.</p> <p>The facility was using 2 different pharmacy services at the time of this issue and is no longer in contract with the pharmacy for resident #2. The current Pharmacy will continue to complete a new admission order review and notify the Director of Nursing of any medication concerns that need to be addressed with physician. Pharmacy will conduct a monthly review of each resident's</p>		

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F 684	<p>Continued From page 7</p> <p>swelling and bruising related to a fall that morning.</p> <p>The nurse's progress note, dated 1/30/19 at 6:49 PM, documented Resident #1 did not have skin changes or notable changes in functional ability. There was no documentation Resident #1 had a fall on 1/30/19 at 7:00 AM.</p> <p>A nurse's progress note, dated 1/31/19 at 1:59 PM, documented Resident #1 left ankle was swollen and bruised from a fall.</p> <p>A physical therapy note, dated 1/31/19 at 3:05 PM, documented Resident #1 had pain to her left ankle and it was swollen.</p> <p>Resident #1's Narcotic Record for Oxycodone 10-325 mg from 1/29/19 to 2/3/19 documented she received one tablet four times a day for severe pain. Resident #1's record did not include documentation of where her pain was located.</p> <p>There were no nurse's progress notes documented on 2/1/19 regarding Resident #1's left ankle injury.</p> <p>A nurse's progress note, dated 2/2/19 at 1:10 AM, documented Resident #1 had no skin changes and was working with therapy to improve functional abilities. The documentation did not include her pain level or a description of Resident #1's left ankle.</p> <p>A physician's order, dated 2/3/19, documented Oxycodone 10-325 mg one tablet every 4 hours as needed for severe pain.</p>	F 684	<p>medication regimen and provide recommendations for DON to review with physicians when concerns are identified.</p> <p>End of month medication orders will be recapitulated by two nurses. Any discrepancies will be addressed immediately with MD and/or pharmacy.</p> <p>Monitoring The IDT reviews occurrences at morning meetings. They will audit records to ensure alert charting is implemented and notes contain thorough documentation related to incident and follow up assessments and resident response. The IDT reviews new admission medications at morning meetings. Monthly Pharmacy report is shared with QAPI Committee. Identified trends are addressed in QAPI on a monthly basis.</p> <p>The Director of Nursing or Licensed designee will perform a random audit of at least 4 residents' records to ensure: assessments are completed and alert charting x 3 days is complete &amp; accurate following a resident incident/accident; medication orders are processed accurately and old orders are discontinued timely.</p> <p>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 6/3/2019.</p> <p>Audit results will be added to the facility</p>		

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F 684	<p>Continued From page 8</p> <p>A nurse's progress note, dated 2/3/19 at 10:54 AM, documented Resident #1 had no new skin issues and no changes in functional ability. The documentation did not include pain level or a description of Resident #1's left ankle.</p> <p>A nurse's progress note, dated 2/3/19 at 8:58 PM, documented Resident #1's left ankle bruise was getting larger and extended up to her knee and her leg was very swollen. There was no documentation the physician was notified of the change of Resident #1's left leg.</p> <p>A nurse's progress note, dated 2/4/19 at 9:47 AM, documented Resident #1's, "left leg is very swollen this morning, which has increased throughout the night." The note documented Resident #1's family member took her to the ER (Emergency Room) to get an x-ray and to rule out blood clots to her left lower leg.</p> <p>Discharge instructions from the hospital, dated 2/4/19, documented Resident #1 was diagnosed with a bimalleolar fracture (parts of both of tibia and fibula are fractured) to her left ankle. The special instructions documented Resident #1 was to remain non-weight bearing on her left ankle and to follow up with an Orthopedic surgeon.</p> <p>A nurse's progress note, dated 2/4/19 at 8:54 PM, documented Resident #1 was non-weight bearing to her left lower extremity. There was no documentation if Resident #1 was wearing a brace and a description of her left lower extremity.</p> <p>A nurse's progress note, dated 2/6/19 at 10:06 PM, documented Resident #1 saw the orthopedic</p>	F 684	QAPI agenda for review x 3 months.		

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F 684	<p>Continued From page 9</p> <p>surgeon and was scheduled for surgery to her left ankle on 2/12/19.</p> <p>A nurse's progress note, dated 2/12/19 at 9:36 AM, documented Resident #1 left the facility for same day surgery to her left ankle.</p> <p>A nurse's progress note, dated 2/12/19 at 8:46 PM, documented Resident #1 returned from the hospital after surgery to repair her left ankle fracture. The note documented she had physician orders to keep her left leg elevated for 48-72 hours, to apply ice to the area, and that she was to be non-weight bearing to her left leg. Resident #1 had an incision to her left ankle and was to wear a boot for stability.</p> <p>The February 2019 TAR, dated 2/12/19 to 2/14/19, documented licensed staff were to elevate Resident #1's affected extremity above her heart for 48-72 hours, apply ice to the wound for 48-72 hours, and to notify the physician for signs and symptoms of severe pain, fever, swelling, impaired circulation, increased numbness, or tingling. The February 2019 TAR did not include documentation licensed staff monitored the incision to her left ankle every shift and monitored the boot placement. The TAR did not direct staff on how often Resident #1 was to wear the boot.</p> <p>On 4/22/19 at 1:15 PM, Resident #1 stated she had a fall 2 days after she was admitted to the facility on 1/28/19. Resident #1 stated she had surgery to repair her broken left ankle on 2/12/19. Resident #1 was observed with a scar approximately an inch long on her inner left ankle. Resident #1 stated she wore a walking</p>	F 684			

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F 684	<p>Continued From page 10</p> <p>boot with velcro straps when she was up and working with therapy staff. Resident #1 stated she had physician orders to apply 50% weight bearing to her left foot.</p> <p>On 4/24/19 at 1:15 PM, Resident #1 stated she fell on 1/30/19 and received a skin tear to her left elbow and twisted her left ankle. Resident #1 stated at the time of the fall, her left ankle did not hurt and she was able to participate with therapy that day. Resident #1 stated by the end of the afternoon, she stated her left ankle was swollen, achy, and bruised. Resident #1 stated around 5:30 PM on 1/30/19, she noticed her left ankle was swollen and it was purple and blue in color from her mid foot up to her shin on the front and inner side of her left leg. Resident #1 stated it looked terrible and she was having pain. Resident #1 stated she had to request ice and the nurses would not even look at her ankle. She stated the nurses kept telling her, it was just a sprain and it was normal to have bruising and swelling. She stated she continued to work with therapy and ambulate with them. Resident #1 stated it was painful, but she was able to tolerate the pain with pain medication and she stated she had neuropathy in both of her legs, so she did not really feel that much anyway. Resident #1 stated the bruising and swelling kept getting worse day after day, and on 2/4/19, she and her son had to insist on going to the ER for x-rays. She was diagnosed with a fracture to her left ankle and had surgery to repair it on 2/12/19. Resident #1 stated her son drove her to the ER in his private car.</p> <p>On 4/24/19 at 2:30 PM, the DNS reviewed the nurse's progress notes and stated the nurses did</p>	F 684			

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F 684	<p>Continued From page 11</p> <p>not document thorough assessments of Resident #1's left ankle and they should have ordered x-rays the day of the incident when her leg became swollen and bruised.</p> <p>Resident #1 was harmed when she experienced a left ankle fracture on 1/30/19 and the facility did not initiate medical interventions and treatment until 2/4/19, 4 days later, to determine the cause of the swelling, bruising, and pain to her left ankle.</p> <p>2. Resident #2 was admitted to the facility on 11/14/18, with multiple diagnoses including GERD.</p> <p>A physician's order, dated 11/15/18, documented Resident #2 was to receive Omeprazole 20 mg one tablet a day for GERD.</p> <p>A physician's order, dated 12/7/18, documented Omeprazole was increased to 40 mg twice a day for GERD. This order was added to the medication administration record in addition to the first order resulting in duplicate dosing of Omeprazole.</p> <p>Resident #2's MARs documented he received Omeprazole 20 mg once daily and the 40 mg twice daily for a total of 60 mg in the morning and 40 mg in the evening from 12/7/18 to 3/2/19.</p> <p>On 4/24/19 at 4:00 PM, the DNS stated the facility should have discontinued the Omeprazole 20 mg daily medication for Resident #2 when the order was increased to 40 mg twice a day. The DNS stated Resident #2 received duplicate doses of the Omeprazole and the physician</p>	F 684			

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F 684	Continued From page 12 should have been notified to clarify the dose for the Omeprazole.	F 684			
F 686 SS=G	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 with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on staff interview, policy review, and record review, it was determined the facility failed to prevent the development of avoidable pressure ulcers. This was true for 2 of 5 residents (#3 and #4) reviewed for pressure ulcers. Resident #3 was harmed when he developed a suspected deep tissue injury that worsened to a Stage 3 pressure ulcer to his right heel. Resident #4 was harmed when he developed a suspected deep tissue injury that worsened to a Stage 3 pressure ulcer to his left heel. Findings include:  The facility's Prevention of Pressure Ulcers policy, dated March 2005, documented, "The purpose of this procedure is to provide information regarding identification of pressure ulcer risk factors and interventions for specific	F 686	F 686 Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)  Corrective Resident #3 and Resident #4 are no longer current residents in the facility.  Identification All residents in the facility have the potential to be affected. By 4/11/2019 a full head-to-toe skin assessment was completed on all residents in the facility by the facility's new Skin Nurse. By 5/27/2019 a Braden Skin at Risk Assessment will be completed on all	5/27/19	

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F 686	<p>Continued From page 13</p> <p>risk factors. Pressure ulcers are usually formed when a resident remains in the same position for an extended period of time causing increased pressure. The facility should have a system/procedure to assure assessments are timely and appropriate and changes in conditions are recognized, evaluated, reported to the practitioner, physician, and family, and addressed." The policy documented interventions and preventive measures for residents with impaired mobility. One preventative measure was, "When in bed, every attempt should be made to float heels (elevate heels off the bed to prevent pressure on them) by placing a pillow from knee to ankle or with other devices as recommended by therapist and prescribed by the physician."</p> <p>The National Pressure Ulcer Advisory Panel website (<a href="http://www.npuap.org">www.npuap.org</a>), accessed on 4/29/19, stated a pressure injury is damage to an area of skin and underlying soft tissue, usually located over a bony prominence, and may be associated with a medical or other device. The pressure injury can appear as intact skin or an open ulcer. A pressure injury results from severe and/or prolonged pressure or pressure with shearing. The website documented the following:</p> <p>* A Stage 2 pressure injury is partial-thickness loss of skin with exposed dermis (thick layer of living tissue below the top of the skin that contains blood capillaries, nerve endings, sweat glands, hair follicles, and other structures). The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue</p>	F 686	<p>current residents by the facility's new Skin Nurse.</p> <p>Measure On 3/28/2019 a new skin nurse was hired; On 4/5/2019, facility identified skin process concerns were addressed thru facility monthly QAPI meeting. As of 5/27/2019 all licensed nurses will receive an in-service education regarding complete and accurate documentation in residents' record related to assessment, documentation and care of pressure ulcers.</p> <p>IDT will review new admits and residents with any significant changes to ensure documentation is complete and accurately reflected in the residents record.</p> <p>Incident/Accident reports are reviewed by IDT when new wounds are discovered. The review process includes ensuring that nurse documents a thorough assessment including measurements; orders for treatment are obtained and the actual skin issue is care planned with appropriate interventions. IDT reviews residents with existing wounds at the NAR (nutrition at risk) meetings which are held weekly.</p> <p>Caregivers report skin related findings to licensed nurses with cares / bathing. Licensed nurses complete skin checks for new issues as well as routine weekly skin</p>		

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F 686	<p>Continued From page 14</p> <p>(pink-red moist tissue that fills an open wound when it starts to heal), slough (non-viable yellow, tan, gray, green, or brown tissue) and eschar (dead or devitalized tissue that is hard or soft in texture - usually black, brown, or tan in color) are not present.</p> <p>* A Stage 3 pressure injury is a "full-thickness skin loss, in which adipose is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible.</p> <p>* An unstageable pressure ulcer is an full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed.</p> <p>The Lippincott Manual of Nursing Practice, tenth edition, stated measures to prevent pressure ulcer development included repositioning every two hours, using special devices to cushion the specific area, and use an alternating pressure mattress or air fluidized bed for patients who are at high risk.</p> <p>1. Resident #3 was admitted to the facility on 1/7/19, with multiple diagnoses including aftercare for a left hip fracture.</p> <p>The admission skin assessment, dated 1/7/19, documented Resident #3 had a wound to his left knee and had multiple scabs on his entire body due to him picking at his skin.</p> <p>Resident #3's skin/integumentary care plan,</p>	F 686	<p>assessments for all residents. Incident/Accident reports are initiated on new wounds. Wounds are measured and assessed weekly by facility skin nurse. Care plans are implemented for skin at risk as well as existing wounds. Progress is re-evaluated and new orders are obtained, as needed.</p> <p>Monitoring The Director of Nursing or Licensed designee will perform a random audit of at least 4 residents <input type="checkbox"/> records to ensure skin breakdown preventions are accurately documented throughout the residents <input type="checkbox"/> record and said preventions are being implemented.</p> <p>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 6/3/2019.</p> <p>Audit results will be added to the facility QAPI agenda for review x 3 months.</p>		

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

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F 686	<p>Continued From page 15</p> <p>dated 1/7/19, included interventions for staff to encourage him to his float heels, provide him assistance with mobility/turning and repositioning during cares, provide a standard facility mattress, and if the resident refused skin related treatment, report the refusal to the charge nurse. The care plan did not include when or how often to float Resident #3's heels with pillows while in bed. The care plan did not include the use of a pressure reduction mattress.</p> <p>A Wound Care Clinic Progress Note, dated 1/11/19, documented Resident #3 was receiving wound care treatment for a left knee wound. The progress note did not document Resident #3 had a wound to his right heel.</p> <p>A Weekly Pressure Ulcer Skin Assessment, dated 1/16/19 at 12:47 PM, documented Resident #3 had an in-house acquired blister to his right heel that was first observed on 1/16/19. The blister was documented as a suspected deep tissue injury with measurements of 7.5 cm x 5.2 cm x 0 cm to his right heel. The physician was notified and the facility received treatment orders for the licensed staff to apply skin prep (a liquid that when applied to the skin forms a protective film or barrier) to the blister, apply a heel foam dressing, and to secure the dressing with Kerlex (gauze) wrap.</p> <p>Resident #3's skin integrity care plan, revised on 1/16/19, documented he needed a pressure relieving/reducing mattress, pillows, and sheepskin padding to protect his skin while in bed.</p> <p>Resident #3's physician's orders, dated 1/17/19,</p>	F 686			

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F 686	<p>Continued From page 16</p> <p>documented staff were to apply an air mattress overlay for skin integrity and preventative measures, and apply skin prep, cover the right heel with a heel foam dressing, and secure with Kerlex wrap every other day.</p> <p>Resident #3's January 2019 TAR documented wound care to his right heel blood blister every other day and that an air mattress was initiated 1/17/19.</p> <p>Resident #3's admission MDS assessment, dated 1/21/19, documented he was cognitively intact and required extensive assistance of two staff members for bed mobility and transfers. The MDS documented Resident #3 was at risk for pressure ulcers, but did not have pressure ulcers at the time of the assessment. The assessment did not include documentation of the pressure wound on his right heel identified on 1/16/19.</p> <p>A Wound Care Clinic Progress Note, dated 1/18/19, documented Resident #3 had a wound to his right calcaneus (heel bone) and to change the dressing every other day. The progress note did not include a description of the right heel wound or type of dressing to use.</p> <p>A Weekly Pressure Ulcer Skin Assessment, dated 1/22/19 at 3:54 PM, documented Resident #3 had a pressure ulcer to his right heel. The right heel pressure ulcer measured 7.5 cm x 5.2 cm. The assessment documented the wound's progress was unchanged and to continue with the treatment to the right heel with skin prep, apply a heel foam dressing, and secure the dressing with a Kerlex wrap.</p>	F 686			

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F 686	<p>Continued From page 17</p> <p>A Weekly Pressure Ulcer Skin Assessment, dated 1/29/19 at 5:04 PM, documented Resident #3's right heel pressure ulcer was improved with the measurements of 7.5 cm x 5.2 cm. The assessment documented Resident #3's wound was an in-house acquired pressure ulcer identified on 1/16/19.</p> <p>Resident #3's 30 day MDS assessment, dated 2/4/19, documented he was at risk for pressure ulcers and he developed one unstageable pressure ulcer with suspected deep tissue injury. As previously noted, the National Pressure Ulcer Advisory Panel website documents when slough or eschar are removed from an unstageable pressure injury, a Stage 3 or Stage 4 pressure injury will be revealed.</p> <p>A Weekly Pressure Ulcer Skin Assessment, dated 2/5/19 at 8:20 PM, documented Resident #3's right heel pressure ulcer, with measurements of 7.5 x 5.3 x 0.5 cm, had deteriorated. The ulcer had a depth of 0.5 cm, which it previously did not. There was no documentation the physician was notified of the deterioration of the right heel pressure ulcer.</p> <p>A Weekly Pressure Ulcer Skin Assessment, dated 2/19/19 at 8:56 PM, documented Resident #3's right heel pressure ulcer had scant amount of serous drainage (thin, watery, clear fluid). The wound measured 7.5 cm x 5.3 cm x 1.4 cm and granulation tissue was present. As previously noted, the National Pressure Ulcer Advisory Panel website documents granulation tissue is not present on a Stage 2 pressure ulcer, however, may be present on a Stage 3 pressure ulcer.</p>	F 686			

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F 686	Continued From page 18  Physician orders, dated 2/26/19, documented Resident #3 was to wear a heel suspension boot to his right foot while in bed.  A Weekly Pressure Ulcer Skin Assessment, dated 3/19/19 at 9:17 PM, documented Resident #3's right heel pressure ulcer had a small amount of serous drainage. The wound had beefy red granulation tissue and measured 7.3 cm x 5.0 cm x 1.3 cm.  Resident #3's record did not include documentation the facility floated his heels from 1/7/19 to 1/16/19.  On 4/24/19 at 3:30 PM, the DNS stated Resident #3's record did not include documentation the facility staff float his heels while he was in bed from 1/7/19 to 1/16/19, to prevent the development of the pressure ulcer to his right heel.  2. Resident #4 was admitted to the facility on 12/6/18, with multiple diagnoses including a left femur (thigh bone) fracture and reduced mobility.  Resident #4's MDS assessments, dated 12/13/18, 12/20/18, 12/27/18, 1/3/19 and 1/31/19, documented he did not have unhealed pressure ulcers. The MDS completed on 2/15/19 documented he had one Stage 3 pressure ulcer.  Resident #4's skin integrity care plan, dated 12/6/18, documented to have staff encourage him to float his heels.  A weekly skin assessment, dated 12/11/18,	F 686			

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F 686	Continued From page 19 documented Resident #4 had a left heel blister.  A physician's order, dated 12/12/18, documented licensed staff were to apply skin prep, apply a cushioned heel dressing, and secure with Kerlex wrap every evening. Resident #4 was referred to a wound care clinic on 1/2/19.  Resident #4's record did not include documentation the facility floated his heels from 12/6/18 to 12/11/18.  On 4/23/19 at 3:15 PM, the DNS stated the facility had identified concerns with skin assessments and preventative measures for pressure ulcers. The DNS stated the facility should have prevented Resident #4's pressure ulcer to his left heel by floating his heels with pillows when he was in bed.	F 686			
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)  § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview, and record review, it was determined the facility failed to ensure a physician's order was in place for a Bipap machine. This was true for 1 of 1 resident (Resident #1) reviewed for	F 695	F 695 Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)  Corrective	5/27/19	

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F 695	<p>Continued From page 20</p> <p>Bipap use. This failure created the potential for harm should residents experience complications from the Bipap machine being administered without physician directions. Findings include:</p> <p>Resident #1 was admitted on 1/28/19, and readmitted to the facility on 4/17/19, with multiple diagnoses including acute respiratory distress, COPD (progressive lung diseases characterized by increasing breathlessness), CHF, and sleep apnea.</p> <p>A nurse's progress note, dated 4/15/19 at 9:03 AM, documented Resident #1's lung sounds were abnormal with diminished sounds in the left lower lobe, and wheezes and crackles heard to the left upper lobe. The progress note documented Resident #1 was unable to stay awake and spilled her breakfast onto the floor. This progress note was sent with her to the physician's appointment that morning.</p> <p>A physician's progress note, dated 4/15/19 at 10:20 AM, documented Resident #1 had a diminished level of alertness since last evening with increased cough, crackles in lungs, and low oxygen saturations. Resident #1 was sent to the ER from the physician's office for further evaluation for possible aspiration pneumonia.</p> <p>The hospital history and physical, dated 4/15/19, documented Resident #1 was hypoxic (lack of oxygen) and had acute respiratory distress and was admitted to the hospital.</p> <p>The hospital discharge orders, dated 4/17/19, documented Resident #1 was to use a Bipap machine at bedtime.</p>	F 695	<p>Resident #1 is no longer a current resident in the facility.</p> <p>Identification According to the CMS 2567 report this was an isolated incident. However, all residents in the facility using a BIPAP/CPAP machines have the potential to be affected. Therefore by 5/27/2019 a one time review of all residents using BIPAP/CPAP machines will be performed by the Director of Nursing or designee to ensure a physician's order is in place for said machine use.</p> <p>Measure Respiratory therapists from SMS (respiratory support contractor) have assessed current residents using CPAP and BIPAP equipment. They provided education for residents related to proper use of their specific devices. Recommendations for settings, cleaning and set up have been addressed with MD. Orders have been updated and added to the TAR and care plans.</p> <p>By 5/27/2019 all licensed nurses will receive an in-service education by the Director of Nursing or licensed designee related to ensuring a physician order is in place for any resident using a CPAP/BIPAP machine, CPAP/BIPAP set up, settings and cleaning of equipment. Competency checklists have been completed for licensed nurses. New admissions are processed by Unit Managers with orders being reviewed and</p>		

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F 695	Continued From page 21  Resident #1's physician orders did not include an order for the Bipap machine.  Resident #1's April 2019 TAR did not include documentation of her use of the Bipap machine at bedtime.  Resident #1's care plan did not include documentation of the use of the Bipap machine at bedtime, the settings for the Bipap machine, and to clean the mask daily after use.  On 4/22/19 at 3:15 PM, Resident #1 was observed in her room with a Bipap machine next to her bed. Resident #1 stated she had used the Bipap at bedtime for the past four years. Resident #1 stated she had used the Bipap machine at night since she was admitted to the facility on 1/28/19. Resident #1 stated she was in the hospital 4/15/19 to 4/17/19 for respiratory failure.  On 4/22/19 at 10:30 PM, Resident #1 was observed sleeping in bed wearing the mask to her Bipap machine.  On 4/22/19 at 10:35 PM, LPN #2 stated Resident #1 had worn the Bipap mask at night since she was admitted to the facility on 1/28/19. LPN #2 stated Resident #1 placed the Bipap mask on herself and removed it herself.  On 4/23/19 at 9:30 AM, LPN #4 stated she received verbal report from the night nurse that morning that Resident #1 removed her Bipap mask in the middle of the night and did not want to put it back on. LPN #4 reviewed Resident #1's	F 695	added to the resident record as indicated.  Any new orders for BIPAP/CPAP use are reviewed the next business day by IDT to ensure new orders have been added to appropriate documentation forms as well as care plan. The respiratory support contractor (SMS) will continue to visit facility every two weeks to ensure settings on machines are appropriate and maintenance is completed on CPAP, BIPAP and oxygen delivery devices. They will provide a print out of changes made or concerns identified for facility follow up.  Monitoring The Director of Nursing or Licensed designee will perform random audits of at least 4 residents using BIPAP/CPAP machines to ensure physician's orders are in place.  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 6/3/2019.  Audit results will be added to the facility QAPI agenda for review x 3 months.		

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

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F 695	Continued From page 22 April electronic TAR and was unable to find orders for the Bipap machine.  On 4/23/19 at 11:20 PM, the DNS stated Resident #1 had a Bipap machine in her room and wore it every night. The DNS was unable to find the physician's orders or the care plan for the Bipap machine and the settings for the Bipap for Resident #1. The DNS stated the unit managers were responsible for transcribing the admission orders to the MAR and TAR. The DNS stated Resident #1's Bipap machine orders were not transcribed to the TAR and were not being monitored by the licensed staff. The DNS stated Resident #1 should have orders and care plan for the Bipap machine and the settings of the Bipap machine.  On 4/23/19 at 12:00 PM, RN #1 stated she was at the facility when Resident #1 returned from the hospital on 4/17/19 and missed transcribing the order for the Bipap to the TAR. RN #1 stated Resident #1 had worn the Bipap machine at bedtime since she was admitted to the facility on 1/28/19.	F 695			
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6)  §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-  §483.45(d)(1) In excessive dose (including duplicate drug therapy); or  §483.45(d)(2) For excessive duration; or	F 757		5/27/19	

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F 757	<p>Continued From page 23</p> <p>§483.45(d)(3) Without adequate monitoring; or</p> <p>§483.45(d)(4) Without adequate indications for its use; or</p> <p>§483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or</p> <p>§483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interview and record review, it was determined the facility failed to provide ongoing monitoring of medication orders for appropriate, effective, and safe medication use. This was true for 1 of 8 residents (Resident #2) reviewed for unnecessary medications. This failure created the potential for harm when residents could have an adverse reaction or side effects from unnecessary medications. Findings include:</p> <p>Resident #2 was admitted to the facility on 11/14/18, with multiple diagnoses including GERD.</p> <p>Resident #2's physician's order, dated 11/15/18, documented Omeprazole 20 mg one tablet a day for GERD.</p> <p>A physician's order, dated 12/07/18, documented Omeprazole was increased to 40 mg twice a day for GERD. This order was added to the medication administration record in addition to the first order, resulting in duplicate dosing of</p>	F 757	<p>F 757 Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6)</p> <p>Corrective Resident # 2 is no longer a current resident in the facility.</p> <p>Identification According to the CMS 2567 report, this was an isolated incident. However all residents in the facility with a physician's order for medications have the potential to be affected.</p> <p>Measure By 5/27/2019 all licensed nurses will receive an in-service education from the Director of Nursing or licensed designee about reviewing physician orders and seeking clarification when changes to existing dose are made. Nurse will seek DC order for existing medication/dose, notify pharmacy and update orders in</p>		

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F 757	Continued From page 24 Omeprazole.  Resident #2's MARs documented he received Omeprazole 20 mg daily and the 40 mg twice daily for a total of 60 mg in the morning and 40 mg in the evening from 12/7/18 to 3/2/19.  Resident #2's monthly pharmacy reviews and physician's orders were reviewed from December 2018 through February 2019 and no changes were documented related to the duplicate orders for Omeprazole.  On 4/24/19 at 4:00 PM, the DNS stated the facility should have discontinued the Omeprazole 20 mg daily medication for Resident #2 when the order was increased to 40 mg twice a day. The DNS stated Resident #2 received duplicate doses for the Omeprazole and the physician should have been notified to clarify the dose for the Omeprazole.	F 757	computer system.  The facility was using 2 different pharmacy services at the time of this issue and is no longer in contract with the pharmacy for resident #2. The current Pharmacy will continue to complete a new admission order review and notify the Director of Nursing of any medication concerns that need to be addressed with physician. Pharmacy will conduct a monthly review of each resident's medication regimen and provide recommendations for DON to review with physicians when concerns are identified.  End of month medication orders will be recapitulated by two nurses. Any discrepancies will be addressed immediately with MD and/or pharmacy.  Monitoring The Director of Nursing or Licensed designee will perform a random audit of at least 4 residents' records to ensure medication orders are processed accurately and old orders are discontinued upon entering the new order, if necessary.  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 6/3/2019.  Audit results will be added to the facility QAPI agenda for review x 3 months.		
F 880	Infection Prevention & Control	F 880		5/27/19	

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F 880 SS=F	Continued From page 25 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 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	F 880			

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F 880	<p>Continued From page 26</p> <p>infections;</p> <p>(iv)When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(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</p> <p>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§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: Based on staff interview, policy review, and review of the infection control log, it was determined the facility failed to report the Influenza A outbreak to the public health authorities for residents and their staff. This was true for 13 of 31 residents (#6, #9-20) residing in the facility from 3/1/19 to 3/31/19, and five staff</p>	F 880	<p>F880 Infection Prevention &amp; Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)</p> <p>Corrective The facility administrator notified the Public Health Department on 4/24/2019 of the Influenza outbreak in the facility on</p>		

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NAME OF PROVIDER OR SUPPLIER  <b>QUINN MEADOWS REHABILITATION AND CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1033 WEST QUINN ROAD POCATELLO, ID 83202</b>		
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F 880	<p>Continued From page 27</p> <p>members, all of whom were confirmed with Influenza A. This failure created the potential for harm to residents, visitors, and staff, when inquiries concerning reportable diseases were not reported per the local public health authorities. Findings include:</p> <p>The facility's Reportable Diseases policy, dated March 2009, included residents or staff suspected or diagnosed as having a reportable communicable/infectious disease, such information be promptly reported to appropriate county and/or state health department officials.</p> <p>The Idaho Reportable Diseases (IDAPA 16.02.10) website: <a href="https://adminrules.idaho.gov/rules/current/16/160210.pdf">https://adminrules.idaho.gov/rules/current/16/160210.pdf</a> included a list of bacteria, viruses, and other important laboratory results to report to the public health authorities. The list included the Novel Influenza A virus and documented the facility was to report the communicable disease within one day.</p> <p>On 4/23/19 at 3:30 PM, the Infection Control Nurse stated the facility had an outbreak of the Influenza A with 14 confirmed cases in early March 2019. The Infection Control Log, however, documented 13 residents were confirmed positive with Influenza A, as follows:</p> <ul style="list-style-type: none"> <li>* Resident #6 and Residents #8 - #17 were confirmed positive with the Influenza A by nasal swab on 3/4/19.</li> <li>* Resident #20 was confirmed positive with the Influenza A on 3/5/19.</li> <li>* Resident #18 was confirmed positive with the Influenza A on 3/7/19.</li> </ul>	F 880	<p>3/4/2019.</p> <p>As of 5/27/2019 a written list was sent to the Public Health Department detailing the necessary information related to the 3/4/2019 Influenza outbreak at the facility.</p> <p><b>Identification</b> All residents, staff and/or visitors in the facility have the potential to be affected.</p> <p><b>Measure</b> The facility has a list of reportable diseases and access to the Idaho Reportable Disease website. On 5/16/2019 Director of Nursing, Administrator, Infection Control Nurse and licensed nurses were educated about the existence and location of this resource as well as the reporting time frame for common infections.</p> <p>A copy of the Idaho Reportable Disease list has been placed at the Nurse <input type="checkbox"/> station. The IDT reviews progress notes related to resident conditions in morning meeting. They refer to the list of reportable diseases as symptoms are identified. The infection control nurse will maintain records and communicate with MD, Administrator and Director of Nursing to ensure the Public Health Department is notified in the event of an outbreak.</p> <p>The Infection Control Nurse maintains a line listing and facility map outlining residents with signs and symptoms of infection. The Infection Control Nurse prepares the monthly infection control</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135136</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/24/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>QUINN MEADOWS REHABILITATION AND CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1033 WEST QUINN ROAD</b> <b>POCATELLO, ID 83202</b>		
(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 880	<p>Continued From page 28</p> <p>* Resident #19 was confirmed positive with the Influenza A on 3/8/19.</p> <p>The Infection Control Nurse stated 5 staff members tested positive for the Influenza A and they did not work in the facility until they received treatment and were able to physically work. The Infection Control Nurse stated she did not report the communicable disease to the public health authorities.</p> <p>On 4/24/19 at 11:00 AM, the Administrator and the DNS stated they were unable to find documentation the public health authorities were notified of the Influenza A outbreak.</p> <p>On 4/24/19 at 4:40 PM, the Administrator stated the Regional Nurse was the interim DNS from 3/5/19 to 3/18/19 and she did not report the Influenza A outbreak to the public health authorities. The Administrator stated he contacted the Department of Public Health and they did not have record of the facility notifying them of the Influenza A outbreak on 3/4/19.</p> <p>On 4/24/19 at 6:08 PM, the DNS stated two residents were discharged to the hospital for treatment of the Influenza A. Resident #6 was discharged to the hospital on 3/11/19 with a confirmed case of the Influenza A, and readmitted on 3/19/19. Resident #9 was discharged to the hospital on 3/9/19 and was discharged home from the hospital. The DNS stated none of the residents that were diagnosed with the Influenza A died from the complications of the outbreak.</p>	F 880	<p>report.</p> <p>Monitoring The Director of Nursing or Licensed designee will review the infection control documentation to ensure the Public Health Department has been notified within the proper timeframe for any resident or staff health conditions that warrant reporting.</p> <p>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 6/3/2019.</p> <p>Audit results will be added to the facility QAPI agenda for review x 3 months.</p>		



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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August 9, 2019

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

Provider #: 135136

Dear Mr. Gannon:

On **April 24, 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 #ID00008057**

**ALLEGATION #1**

Multiple resident's developed wounds in the facility.

**FINDINGS #1:**

An unannounced complaint survey was conducted on 4/22/19 to 4/25/19. During the survey, observations were conducted, resident records were reviewed, facility grievances were reviewed, residents and family members were interviewed, and staff were interviewed.

During the investigation two residents were observed and five resident's records, which included three closed records, were reviewed for Quality of Care and wound management. Multiple interviews were conducted with residents and family members. Multiple staff members were interviewed and observed regarding wound management and pressure ulcers. Facility abuse

allegations, grievances, and Resident Council minutes were reviewed.

Facility grievances did not document concerns with pressure ulcers.

Five residents' records were reviewed for pressure ulcers, including a resident admitted to the facility in January 2019. The resident's record included the admission skin assessment, dated 1/7/19, which documented the resident had a wound to his left knee and had multiple scabs on his entire body due to him picking at his skin. A Wound Care Clinic Progress Note, dated 1/11/19, documented the resident was receiving wound care treatment for a left knee wound. The progress note did not document the resident had a wound to his right heel. A Weekly Pressure Ulcer Skin Assessment documented the resident had an in-house acquired blister to his right heel. The blister was documented as a suspected deep tissue injury with measurements of 7.5 cm x 5.2 cm x 0 cm to his right heel. The physician was notified and the facility received treatment orders for the licensed staff to apply skin prep (a liquid that when applied to the skin forms a protective film or barrier) to the blister, apply a heel foam dressing, and to secure the dressing with Kerlex (gauze) wrap. The resident's record did not include documentation the facility floated his heels to prevent further deterioration of the pressure ulcer.

The DNS stated the resident developed pressure ulcers and the facility did not have preventative interventions in place prior to the development of the pressure ulcers.

Based on the results of the investigation, the allegation was substantiated. A deficiency was cited at F686 as it relates to the failure of the facility to ensure residents did not develop preventable pressure ulcers.

#### CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

#### ALLEGATION #2

The facility failed to ensure residents did not fall.

#### FINDINGS #2

During the investigation five residents were observed and eight resident's records, which included three closed records, were reviewed for accidents and incidents. Interviews were conducted with residents and family members. Staff members were interviewed regarding accidents and incidents and the investigation process. Facility grievances and Resident Council minutes were also reviewed.

One of eight residents' records documented issues with investigations into falls and their causes.

The resident's record documented the resident was admitted in January 2019, and experienced a fall two days after admission to the facility and the facility did not reassess the resident for injury after the ankle was documented as swollen and bruised until the residents family took the resident to the hospital four days later.

A resident stated she had a fall 2 days after she was admitted to the facility. The resident stated she had surgery to repair her broken left ankle on two weeks later. The resident was observed with a scar approximately an inch long on her inner left ankle. The resident stated she wore a walking boot with Velcro straps when she was up and working with therapy staff. The resident stated she had physician orders to apply 50% weight bearing to her left foot.

The resident stated she fell and received a skin tear to her left elbow and twisted her left ankle. The resident stated at the time of the fall, her left ankle did not hurt and she was able to participate with therapy that day. The resident stated by the end of the afternoon her left ankle was swollen, achy, and bruised. The resident stated she noticed her left ankle was swollen and it was purple and blue in color from her mid foot up to her shin on the front and inner side of her left leg. The resident stated it looked terrible and she was having pain. The resident stated she had to request ice and the nurses would not even look at her ankle. She stated the nurses kept telling her, it was just a sprain and it was normal to have bruising and swelling. She stated she continued to work with therapy and ambulate with them. She stated it was painful, but she was able to tolerate the pain with pain medication and she stated she had neuropathy in both of her legs, so she did not really feel that much anyway. The resident stated the bruising and swelling kept getting worse day after day, and 5 days later she and her son had to insist on going to the ER for x-rays. She was diagnosed with a fracture to her left ankle and had surgery to repair it. The resident stated her son drove her to the ER in his private car.

The DNS reviewed the nurse's progress notes and stated the nurses did not document thorough assessments of the resident's left ankle and they should have ordered x-rays the day of the incident when her leg became swollen and bruised.

Based on the results of the investigation, the allegation was substantiated, a deficiency was cited at F684 as it relates to the failure of the facility to ensure residents who fell were assessed, evaluated, and treated appropriately.

#### CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

#### ALLEGATION #3

The facility had an outbreak of the flu and residents were transferred to the hospital and one resident passed away.

### FINDINGS #3

During the investigation, residents were observed for infection control concerns and development of infections. Resident Council meeting minutes were reviewed, facility grievances were reviewed, infection control logs were reviewed, and residents and family members were interviewed.

During observations of residents and staff members interacting, no concerns were identified with infection control concerns.

Resident Council Meeting minutes and facility grievances did not document concerns with residents developing an outbreak of the flu.

Several residents and two family members said there was an outbreak of the Influenza A in March 2019.

The infection control nurse stated 13 residents had confirmed diagnosis of Influenza A and 5 staff members had confirmed cases of Influenza A. The Infection Control Nurse stated she did not report the communicable disease to the public health authorities.

The Administrator and the DNS stated they were unable to find documentation the public health authorities were notified of the Influenza A outbreak.

The Administrator stated the Regional Nurse was the interim DNS from 3/5/19 to 3/18/19 and she did not report the Influenza A outbreak to the public health authorities. The Administrator stated he contacted the Department of Public Health and they did not have record of the facility notifying them of the Influenza A outbreak on 3/4/19.

The DNS stated two residents were discharged to the hospital for treatment of Influenza A. A resident was discharged to the hospital on 3/11/19 with a confirmed case of Influenza A, and readmitted on 3/19/19. Another resident was discharged to the hospital on 3/9/19 and was discharged home from the hospital.

Based on the investigative findings, the allegation was substantiated and a deficiency was cited at F880 as it relates to the facility's failure to report an outbreak of Influenza A.

### CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

#### ALLEGATION #4

Residents privacy was not respected and personal information was shared.

#### FINDINGS #4:

During the investigation, all residents were observed for privacy and respect of personal information. Resident Council meeting minutes were reviewed, facility grievances were reviewed, and multiple residents and family members were interviewed regarding privacy.

During observations of residents and staff members interacting, there were no concerns identified. The residents were observed being provided cares behind closed doors and clinical records were only shared with qualified staff.

Several residents said the facility did not share their private information with others.

Multiple CNAs and nurses said the facility took residents privacy seriously and they would never share the residents' private information with others.

The allegation was unsubstantiated due to lack of evidence regarding unprotected information shared with others.

#### CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

#### FINDINGS #5:

During the investigation, observations were conducted and eight resident's records, which included one closed record, were reviewed for medication management. Interviews were conducted with residents and family members. Staff members were interviewed and observed regarding abuse. Facility abuse allegations, grievances, and Resident Council minutes were reviewed.

Facility abuse investigations did not document concerns with over medicating residents or include an investigation in regards to that.

All eight residents' records were reviewed for medication management, including a resident admitted to the facility in November 2018.

During the review of the records one resident, admitted November 2018, had a physician's order for Omeprazole 20 mg one tablet a day for GERD.

Steve Gannon, Administrator  
August 9, 2019  
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A physician's order, dated almost a month later, documented Omeprazole was increased to 40 mg twice a day for GERD. This order was added to the medication administration record in addition to the first order, resulting in duplicate dosing of Omeprazole.

The resident's Medication Administration Records documented he received Omeprazole 20 mg daily and the 40 mg twice daily for a total of 60 mg in the morning and 40 mg in the evening for almost three months.

The resident's monthly pharmacy review and physician's orders were reviewed from December 2018 through February 2019 and no changes were documented related to the duplicate orders for Omeprazole.

The DNS stated the facility should have discontinued the Omeprazole 20 mg daily medication for the resident when the order was increased to 40 mg twice a day. The DNS stated the resident received duplicate doses for the Omeprazole and the physician should have been notified to clarify the dose for the Omeprazole.

Based on the results of the investigation, the allegation was substantiated. A deficiency was cited at F757 as it relates to the failure of the facility to ensure residents' medications were provided appropriately.

#### CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

Thank you for the courtesies and assistance extended to us during our visit. Based on the findings of the investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this findings letter, as it will be addressed in the provider's Plan of Correction.

If you have any questions, comments or concerns regarding this matter, please contact Laura Thompson, RN, or Belinda Day, RN, Supervisors, Long Term Care Program at (208) 334-6626, Option #2.

Sincerely,



LAURA THOMPSON, RN, Supervisor  
Long Term Care Program  
LT/slj



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August 26, 2019

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

Provider #: 135136

Dear Mr. Gannon:

On **April 22, 2019** through **April 24, 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 #ID00008086**

ALLEGATION #1:

The facility staff were rough with residents during cares.

FINDINGS #1:

During the investigation 5 residents were observed and 8 resident's records, which included 3 closed records, were reviewed for Quality of Care, abuse, and Bipap (an electronic breathing device used in the treatment of sleep apnea, lung disease, and to treat respiratory weakness) respiratory management. The facility administrative documents were reviewed, residents and staff were interviewed, and observations were conducted for abuse. Facility abuse, grievances, and Resident Council minutes were reviewed.

A facility abuse investigation documented concerns with staff to resident allegations of abuse.

Steve Gannon, Administrator  
August 26, 2019  
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All 8 residents' records were reviewed for potential abuse concerns, including two residents, one admitted in January 2019 and one admitted March 2019.

During the review of the records for one resident, admitted January 2019, an abuse investigation was initiated April 2019, when a CNA stated to the resident if you stay in bed to change your linens, it will be rough on you. The resident stated it was a misinterpretation with the CNA and did not feel she was being abused. The resident stated the CNA was trying to explain to her, that since she was in pain, it was going to be more painful if she stayed in bed, instead of getting out of the bed, while the CNAs were providing a linen change to her bed.

Based on the results of the investigation, the allegation was not substantiated, and no deficient practice was currently identified due to the facility investigated the allegation appropriately.

#### CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

#### ALLEGATION #2:

The facility did not provide services for the use of Bipap's to residents.

#### FINDINGS #2:

Based on observation, staff and resident interview, and record review, it was determined the facility failed to ensure physician's order was in place for a resident that required the Bipap machine.

The resident was observed with a Bipap machine at her bedside. The resident stated she has used the Bipap at bedtime every night for the past four years. The resident's record did not document she was using the Bipap consistently at bedtime.

Based on the results of the investigation, the allegation was substantiated. A deficiency was cited at F656 as it relates to the failure of the facility to ensure the resident's care plan was implemented for her respiratory needs. A deficiency was cited at F695 as it relates to the failure of the facility to ensure respiratory treatments were provided to a resident.

#### CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

#### ALLEGATION #3:

Steve Gannon, Administrator  
August 26, 2019  
Page 3 of 2

The facility was not assessing residents after falls with a major injury.

FINDINGS #3:

Based on record review and interviews with staff and residents, it was determined the facility did not provide necessary care and treatment for a resident who fell and obtained a major injury.

A resident's record documented she fell on 1/30/19 in the morning and by the evening of the same day her ankle was swollen, painful, and bruised, which the facility documented it was a sprain and applied ice. On 2/4/19, the resident and her family insisted that she go to the ER for an x-ray and it was determined the resident fractured her ankle.

Based on the results of the investigation, the allegation was substantiated. A deficiency was cited at F684 as it relates to the failure of the facility to ensure the resident received treatment for a major injury after a fall.

CONCLUSIONS:

Substantiated. Federal 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,



Belinda Day, RN, Supervisor  
Long Term Care Program

BD/lj