



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

BRAD LITTLE – Governor  
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TAMARA PRISOCK—ADMINISTRATOR  
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November 29, 2019

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

Provider #: 135136

Dear Mr. Bell:

On **November 21, 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 no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

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

Troy Bell, Administrator  
November 29, 2019  
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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 **December 9, 2019**. Failure to submit an acceptable PoC by **December 9, 2019**, may result in the imposition of penalties by **January 1, 2020**.

The components of a Plan of Correction as required by CMS must:

- Address what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- Address how you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- Address what measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;
- Indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained; and
- Include dates when corrective action will be completed in column (X5).

If the facility has not been given an opportunity to correct, the facility must determine the date compliance will be achieved. If CMS has issued a letter giving notice of intent to implement a denial of payment for new Medicare/Medicaid admissions, consider the effective date of the remedy when determining your target date for achieving compliance.

- The administrator must sign and date the first page of the federal survey report, Form CMS-2567 and the state licensure survey report, State Form (if applicable).

All references to federal regulatory requirements contained in this letter are found in *Title 42, Code of Federal Regulations*.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **December 26, 2019 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **February 21, 2020**. A change in the seriousness of the deficiencies on **January 5, 2020**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by

Troy Bell, Administrator  
November 29, 2019  
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**February 21, 2020** includes the following:

Denial of payment for new admissions effective **February 21, 2020**. [42 CFR §488.417(a)]

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

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **May 21, 2020**, 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 Belinda Day, RN or Laura Thompson, RN, Supervisors Long Term Care, Bureau Chief, 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.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **February 21, 2020** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

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

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

Troy Bell, Administrator  
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- 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 **December 9, 2019**. If your request for informal dispute resolution is received after **December 9, 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 Belinda Day, RN, or Laura Thompson, RN, Supervisors, Long Term Care Program at (208)334-6626, option #2.

Sincerely,



Laura Thompson, RN, Supervisor  
Long Term Care Program

lt/lj

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>11/21/2019</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 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 a complaint survey conducted from 11/19/19 - 11/21/19.  The survey was conducted by:  Monica Meister, QIDP, Team Coordinator Karen George, RN  Abbreviations used in this report:  BIMS - Brief Interview for Mental Status CNA = Certified Nursing Assistant DON = Director of Nursing	F 000			
F 684 SS=D	Quality of Care CFR(s): 483.25  § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on policy review, record review, and interviews, it was determined the facility failed to ensure residents received treatment and care in accordance with their Care Plans for 1 of 4 residents (Resident #3) residing in the facility whose Care Plans were reviewed. This resulted in a resident not receiving a scheduled medication for 5 days. The findings include:	F 684	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility <input type="checkbox"/> s	12/16/19	

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

TITLE

(X6) DATE

Electronically Signed

12/05/2019

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 684	<p>Continued From page 1</p> <p>1. The facility's Unavailable Medication policy, dated 11/1/19, stated "Medications may be unavailable for a number of reasons. Staff shall take immediate action when it is known that the medication is unavailable...Notify physician of inability to obtain medication upon notification or awareness that medication is not available. Obtain alternative treatment orders and/or specific orders for monitoring resident while medication is on hold...If a resident misses a scheduled dose of medication, staff shall follow procedures for medication errors, including physician/family notification, completion of a medication error report."</p> <p>Resident #3 was admitted to the facility on 1/28/14 and her diagnoses included gout (a form of arthritis characterized by severe pain, redness, and tenderness in joints).</p> <p>Resident #3's Care Plan, initiated 10/31/18, stated "I have a potential mood problem r/t [related to] potential for anxiety r/t concerns regarding possibility of unmet needs...I will feel safe and well cared for and will have needs met during facility stay...Administer medications as ordered."</p> <p>Resident #3 was interviewed on 11/19/19 from 3:55 - 4:10 PM. During the interview, Resident #3 stated that "about a month ago" the facility ran out of her medication and her right leg "swelled up."</p> <p>Resident #3's current physician order documented Resident #3 received Uloric 40 mg (milligrams) each day for gout and had been receiving the medication since 2/20/18. Uloric is</p>	F 684	<p>credible allegation of compliance.</p> <p>1. Immediate action(s) taken for the resident(s) found to have been affected include: Resident #3 has received the medication daily from 11/7/19 to current according to care plan. The DNS conducted an audit of both med carts to ensure all medications are currently available as ordered.</p> <p>2. Identification of other residents having the potential to be affected was accomplished by: The nursing management team reviewed the Unavailable Medication facility policy. Nursing management reviewed all patient Medication Care Plans and the individual MARs to identify and audit for any other potential errors which might have occurred in regard to unavailable medications.</p> <p>3. Actions taken/systems put into place to reduce the risk of future occurrence include: All Licensed Nursing staff will be inserviced on the facility policy for Unavailable Medications. An online course detailing and explaining the policy with a documented course quiz will be sent to all licensed nurses to be completed by December 15th. This medication, Uloric, has been added to the Pyxis machine for immediate availability when required.</p>		

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F 684	<p>Continued From page 2</p> <p>a xanthine oxidase inhibitor used to treat excess uric acid in the blood in patients with gout.</p> <p>Resident #3's Nursing Progress Notes, dated 11/1/19 - 11/18/19, did not contain evidence of skin concerns or swelling to Resident #3's legs.</p> <p>However, the Nursing Progress Notes contained the following entries related to the Uloric medication:</p> <ul style="list-style-type: none"> <li>- 11/2/19: "on order"</li> <li>- 11/3/19: "on order"</li> <li>- 11/4/19: "reorder in progress"</li> <li>- 11/5/19: There was no entry related to the medication.</li> <li>- 11/6/19: "na [not applicable]"</li> </ul> <p>Additionally, Resident #3's MAR, dated 11/1/19 - 11/18/19, documented Resident #3 did not receive her daily Uloric 40 mg from 11/2/19 - 11/4/19 and on 11/6/19.</p> <p>When asked how Resident #3 was able to receive medication on 11/5/19 but did not receive the medication on 11/6/19, the DON stated on 11/20/19 at 1:40 p.m., she had called the nurse who made an entry on the MAR and it was accidentally clicked to show it was given, and the nurse forgot to go back and change the entry. The DON stated Resident #3 did not get the medication on 11/5/19.</p> <p>When asked about the medication, the DON stated on 11/20/19 at 2:10 p.m., the medication was not ordered until 11/7/19 due to an oversight and Resident #3's Care Plan was not implemented as written. When asked about the facility's policy for unavailable medications, the</p>	F 684	<p>4. How the corrective action(s) will be monitored to ensure the practice will not recur:</p> <p>The Director of Nursing Services (DNS), or designee, will complete weekly MAR audits of 10 charts for 4 consecutive weeks, biweekly for 4 weeks, and then monthly x3 months to monitor that the policy is being followed. The DNS or designee will strive to ensure all appropriate interventions have been put in place to reduce the risk of future errors/non-compliance with medication policy and so that medication care plans are strictly followed.</p> <p>Results of Audit tools will be presented monthly at QAPI meeting for compliance and follow-up.</p> <p>ReliaMed, a medication management software linked to OmniCare, has been initiated for all long-term residents. This system will automatically cycle order every 30 days.</p> <p>Audited records will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee.</p>		

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F 684	Continued From page 3 DON stated on 11/20/19 at 3:45 PM, Resident #3's physician was not notified, and no medication error reports were completed as per policy.	F 684			
F 689 SS=D	The facility failed to ensure Resident #3 received treatment and care in accordance with her Care Plan. Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)  §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and  §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on policy review, record review, and interview, it was determined the facility failed to ensure interventions were consistently implemented to prevent falls for 1 of 2 residents (Resident #6) whose closed records were reviewed for falls. This resulted in a resident not receiving supervision as identified in her Care Plan and sustaining a fall with injury. The findings include:  1. The facility's "Falls and Fall Risk, Managing" policy, dated 9/2015, stated "Staff will identify and implement relevant interventions...to try to minimize serious consequences of falling."  Resident #6 was re-admitted to the facility on 3/19/19 with diagnoses including acute	F 689	1. Immediate action(s) taken for the resident(s) found to have been affected include: Resident #6 has been discharged from the facility and is no longer affected.  2. Identification of other residents having the potential to be affected was accomplished by: The nursing management team reviewed the MDS Assessments for all residents who have been identified as having a potential risk for falls. Fall and safety risk assessments are complete and interventions currently in place are appropriate. There are no residents currently care planned for a 1-1.	12/16/19	

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F 689	<p>Continued From page 4</p> <p>respiratory failure, dementia, and a wedge compression fracture of unspecified lumbar vertebra (the most common type of compression fracture is a wedge fracture, in which the front of the vertebral body collapses but the back does not, meaning that the bone assumes a wedge shape and compression fractures usually occur in the thoracic (middle) or lumbar (lower) spine). Her most current BIMS score was 00, indicating a severe cognitive impairment.</p> <p>Resident #6's Care Plan, initiated 3/15/18 and revised 4/23/19, stated she was a high risk for falls due to impaired balance and the Intervention section, initiated 6/1/19, stated "1:1 staffing 24 hrs/day [24 hours a day]."</p> <p>A Nursing Progress Note, dated 7/24/19, stated Resident #6 was found in her room, on the floor and on her right side. Resident #6 was sent to the local emergency room and x-rays showed Resident #6 sustained a right acetabular fracture (a break in the socket portion of the "ball-and-socket" hip joint). The Progress Note stated Resident #6 was not to bear weight on her right leg, she was placed on 1:1 supervision 24 hours a day, and she was a 2-person transfer.</p> <p>A Nursing Progress Note, dated 9/13/19, stated Resident #6 was found on the floor next to her bed, and complained of pain to her right hip. Resident #6 was sent to the local emergency room and x-rays were obtained with no fractures noted.</p> <p>An incident/accident report, dated 9/13/19, stated Resident #6's 1:1 staff left the room and did not wait for her relief staff. The report contained a</p>	F 689	<p>3. Actions taken/systems put into place to reduce the risk of future occurrence include: All Licensed Nursing staff will be inserviced on the facility policy for Accidents and Supervision and 1-1 staffing. All resident falls/accidents will be reviewed daily by the nursing management team to ensure appropriate implementation of safety interventions including updating the plan of care.</p> <p>4. How the corrective action(s) will be monitored to ensure the practice will not recur: The nursing management team will review each incident report upon occurrence to ensure appropriate interventions are implemented and an updated plan of care is complete. The Director of Nursing Services (DNS), or designee, will then complete weekly incident and accident report audits for 4 consecutive weeks, biweekly audits for 4 weeks, and then monthly x3 months and provide continued/reinforced training and education as needed. The DNS or designee will ensure all appropriate interventions have been put in place to reduce the risk of future non-compliance with the facility Accidents and Supervision and 1-1 staffing policy. Results of Audit tools will be presented monthly at QAPI meeting for compliance and follow-up, which can result in staff re-education and/or disciplinary action.</p>		

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

PRINTED: 12/17/2019  
FORM APPROVED  
OMB NO. 0938-0391

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F 689	<p>Continued From page 5</p> <p>hand-written statement to Resident #6's physician which documented Resident #6 sustained a skin tear to the back of her right hand due to the fall.</p> <p>When asked, the DON stated during an interview on 11/21/19 from 8:21 - 8:33 AM, Resident #6's Care Plan related to supervision was not implemented which resulted in Resident #6 sustaining an unwitnessed fall.</p> <p>The facility failed to ensure interventions were consistently implemented to prevent falls for Resident #6.</p>	F 689	<p>Audited records will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee.</p>		



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January 21, 2020

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

Provider #: 135136

Dear Mr. Bell:

On **November 19, 2019** through **November 21, 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 #ID00008233**

**ALLEGATION #1:**

The facility does not have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure residents are assisted with activities of daily living which is resulting in avoidable falls and residents enduring increased pain and increased risk for skin breakdown due to being left in sitting positions for extended periods as well as residents experiencing pain and/or injury with positioning.

**FINDINGS #1:**

During the survey, observations, as-worked schedules, record review, and interviews were conducted.

On 11/19/19 from 3:10 to 4:24 PM, 17 of 30 residents were interviewed about the facility's care and services provided to them. Each of the residents reported they were pleased with their care and services.

One resident's daughter was present during the interview and stated the staff were gentle and caring, and she had never witnessed staff being "rough" with any resident. The residents were asked about their experiences related to toileting accidents, positioning needs, illnesses and pain management, timeliness of medication, falls with and without injury, and call light response times. All 17 residents reported they had not had toileting accidents, unmet positioning needs, or falls due to a lack of staff. All 17 residents stated the facility had sufficient staff and when they used their call lights, staff usually responded within 5 minutes and the longest wait time was 10 minutes. All 17 residents stated staff were quick to respond to reports of illness or pain.

Four months of as-worked schedules, dated 7/1/19 to 11/20/19, documented the facility had sufficient numbers of Certified Nursing Assistants (CNAs), Registered Nurses (RNs), Licensed Practical Nurses (LPNs), and Restorative Aides (RAs) working. The schedules showed frequently 2-3 LPNs, 1-2 RNs, 4 CNAs, and a Restorative Aide on shift during the day and evening shifts, and 2 LPNs, 1 RN, and 3 CNAs on the night shift.

Seven residents' records were selected for review. Of those 7 records, 3 were closed records (meaning the resident no longer resided in the facility). One closed record documented the resident had a 1:1 staff due to the resident's lack of safety awareness, weakness, and poor balance. The resident's care plan stated the resident was at high risk for falls due to impaired balance and the intervention section, initiated 6/1/19, stated "1:1 staffing 24 hrs/day {24 hours a day}."

The resident's record documented they had two falls during a two-month period.

A Nursing Progress Note stated the resident was found on the floor and on the resident's right side, in July 2019. The resident was sent to the local emergency room and x-rays showed the resident sustained a right acetabular fracture (a break in the socket portion of the "ball-and-socket" hip joint). The Progress Note stated the resident was not to bear weight on the right leg, 1:1 supervision 24 hours a day was implemented, and the resident was a 2-person transfer.

Another Nursing Progress Note stated the resident was found on the floor next to the bed, and the resident complained of pain to the right hip in September 2019. The resident was sent to the local emergency room and x-rays were obtained with no fractures noted.

An incident/accident report, dated 9/2019, stated the resident's 1:1 staff left the room and did not wait for oncoming staff to relieve her. The report contained a hand-written statement to the resident's physician which documented the resident sustained a skin tear to the back of the right hand due to the fall.

When asked, the Director of Nursing (DON) stated during an interview on 11/21/19 from 8:21-8:33 AM, the resident's care plan related to supervision was not implemented which resulted in the resident sustaining an unwitnessed fall.

It could not be determined that the facility did not have sufficient numbers of nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure residents were assisted with activities of daily living, that residents were not enduring increased pain and increased risk for skin breakdown due to being left in sitting positions for extended periods, or that residents experienced pain and/or injury with positioning. Therefore the allegation was unsubstantiated. However, the facility failed to ensure a resident's care plan interventions were consistently implemented to prevent a fall. Therefore, deficient practice was identified and cited at F689.

**CONCLUSIONS:**

Substantiated. Federal deficiencies related to the allegation are cited.

**ALLEGATION #2:**

Residents are not treated with dignity and respect.

**FINDINGS #2:**

During the survey, residents and family were interviewed, resident records were reviewed, Resident Council meeting minutes were reviewed, and facility grievances were reviewed.

On 11/19/19 from 3:10 - 4:24 PM, 17 of 30 residents were interviewed about voiced concerns and grievances, retaliation, and staffs' treatment of residents related to dignity and respect. All 17 residents reported they had never experienced retaliation in response to voiced concerns or grievances. All residents stated any voiced concerns or filed grievances were dealt with in a timely manner and they were pleased with the outcome. All residents stated they were treated with dignity and respect. One resident's daughter was present during the interview and stated the staff were gentle and caring, and she had never witnessed staff being disrespectful or retaliatory.

Four months of grievances, dated 7/1/19 - 11/20/19, were reviewed and contained investigations into concerns expressed by residents and/or their family members. The grievances all contained sufficient information and corrective action to resolve concerns along with on-going follow-up by the Administrator to ensure the concerns were resolved to the satisfaction of the residents.

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Additionally, 4 months of Resident Council Meeting minutes, dated 7/1/19 - 11/20/19, were reviewed and did not contain information related to retaliation or a lack of dignity and respect toward the residents.

Seven residents' records, including 3 closed records, were selected for review. None of the records contained evidence of concerns related to retaliation or a lack of dignity and respect being provided to the residents.

It could not be determined that residents were not treated with dignity and respect.

Based on the investigative findings, the allegation could not be substantiated, and no deficient practice was identified.

**CONCLUSIONS:**

Unsubstantiated. Lack of sufficient evidence.

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

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/lj