



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RUSSELL S. BARRON – Director

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
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BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
FAX: (208) 364-1888
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July 24, 2017

Darwin Royeca, Administrator
Safe Haven Care Center of Pocatello
1200 Hospital Way
Pocatello, ID 83201-2708

Provider #: 135071

Dear Mr. Royeca:

On **July 13, 2017**, we conducted an on-site revisit and a complaint investigation to verify that your facility had achieved and maintained compliance. We presumed, based on your allegation of compliance, that your facility was in substantial compliance as of **June 12, 2017**. However, based on our on-site revisit we found that your facility is not in substantial compliance with the following participation requirements:

- **F0323 -- S/S: G -- 483.25(d)(1)(2)(n)(1)-(3) -- Free Of Accident Hazards/supervision/devices**
- **F0328 -- S/S: D -- 483.25(b)(2)(f)(g)(5)(h)(i)(j) -- Treatment/care For Special Needs**
- **F0441 -- S/S: D -- 483.80(a)(1)(2)(4)(e)(f) -- Infection Control, Prevent Spread, Linens**
- **F0520 -- S/S: F -- 483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) -- Qaa Committee-Members/meet Quarterly/plans**
- **F0225 -- S/S: D -- 483.12(a)(3)(4)(c)(1)-(4) -- Investigate/report Allegations/individuals**
- **F0281 -- S/S: E -- 483.21(b)(3)(i) -- Services Provided Meet Professional Standards**
- **F0312 -- S/S: D -- 483.24(a)(2) -- Adl Care Provided For Dependent Residents**
- **F0463 -- S/S: D -- 483.90(g)(2) -- Resident Call System - Rooms/toilet/bath**
- **C0000 -- S/S: -- 16.03.02 -- Initial Comments**
- **C0762 -- S/S: -- 02.200,02,c,ii -- When Average Census 60-89 Residents**

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

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **August 3, 2017**.

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

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

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

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

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

As noted in the Bureau of Facility Standards' letter of **April 27, 2017** following the survey of **March 23, 2017**, we have already made the recommendation to the Centers for Medicare and Medicaid Services (CMS) for Denial of Payment for New Admissions effective **June 23, 2017** and termination of the provider agreement on **September 23, 2017**, if substantial compliance is not achieved by that time.

The findings of non-compliance on **July 13, 2017**, has resulted in a continuance of the remedy(ies) previously mentioned to you by the CMS.

- DPNA made on or after **June 23, 2017**
- A civil money penalty

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

If you believe the deficiencies have been corrected, you may contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 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.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You may also contest scope and severity assessments for deficiencies, which resulted in a finding of SQC or immediate jeopardy. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

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

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

- BFS Letters (06/30/11)

2001-10 Long Term Care Informal Dispute Resolution Process

Darwin Royeca, Administrator
July 24, 2017
Page 4 of 4

2001-10 IDR Request Form

This request must be received by **August 3, 2017**. If your request for informal dispute resolution is received after **August 3, 2017**, 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 David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2.

Sincerely,

A handwritten signature in dark ink, appearing to read "D. Scott". The signature is written in a cursive, somewhat stylized font.

David Scott, RN, Supervisor
Long Term Care

DS/lj
Enclosures

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

PRINTED: 08/17/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 07/13/2017
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCATELLO, ID 83201		
(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 A follow-up survey and complaint investigation survey was conducted at the facility on July 10, 2017 to July 13, 2107. The surveyors conducting the survey were: Jenny Walker, RN, Team Coordinator Brad Perry, LSW Edith Cecil, RN Cecilia Stockdill, RN Abbreviations: ADL's = Activity of Daily Living COO = Chief of Operations COPD = Chronic Obstructive Pulmonary Disease CNA = Certified Nurse Assistant DNS = Director of Nursing IDT = Interdisciplinary Team LN = Licensed Nurse MAR = Medication Administration Record MDS = Minimum Data Set	{F 000}			
F 225 SS=D	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect,	F 225			8/15/17

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

TITLE

(X6) DATE

Electronically Signed

08/01/2017

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 225	Continued From page 1 exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated.	F 225			

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F 225	Continued From page 2 (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, policy review, and resident and staff interview, it was determined the facility failed to ensure an altercation between residents was reported to the state agency and a resident's fall was thoroughly investigated. This was true for 3 of 10 (#8, #29, and #32) residents reviewed for abuse and neglect and created the potential for harm if potential abuse or neglect to not be investigated or reported. The facility's undated abuse and neglect policy documented, "Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including Bureau of Facility Standards...) in accordance with State and Federal Law...The facility will complete an			F 225	F 225 483.12 (a)(3)(4)(c)-(4) Investigate/Report Allegations/Individuals. This facility does ensure that an altercation between residents was reported to the state agency and resident's fall was thoroughly investigated. Corrective action(s) accomplished for those residents found to have been affected by the deficient practice: Resident #8 and #32 incident of altercation have already been reported to the state portal on 07/25/17. Resident #29 fall investigation have been reviewed, completed, and the occurrence report with root cause analysis of fall was attached to the investigation on 07/27/17. Identification of other residents having the same potential to be affected by the same practice and what corrective action(s)		

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F 225	Continued From page 3 investigation that will be completed and turned in to The Bureau of Facility Standards within five (5) business days." The facility's Guidelines For An Occurrence Report, dated 5/20/16, documented, "Resident To Resident Contact...We must report these incidents to that state within 24 hours so it is important that administration is notified." 1. An Incident Report, dated 5/31/17, documented that on 5/30/17 at 7:30 am, Resident #32 was standing behind Resident #8 in the dining room, yelling at her, kneeling her in the back, and pushing her wheelchair into the table in front of her. The report documented a staff member placed herself between the residents to protect them. Resident #8 did not sustain an injury, and the Administrator interviewed Resident #8 on 5/31/17 at 10:45 am regarding the incident. On 7/11/17 at 10:30 am, Resident #8 said she was in her wheelchair in the dining room on 5/30/17 when Resident #32 came up behind her, grabbed her wheelchair and pushed her into the table several times and rubbed his knee into her back before a staff member intervened. She said she was not injured, but the incident frightened her. On 7/13/17 at 11:10 am, the Administrator said he reported the incident to the state agency, but could not find the report when he looked for it on the State reporting system. The Administrator said he may have determined it was not a reportable incident because he ruled out abuse within 24 hours of the event, and thought he	F 225	taken: This deficiency is an isolated deficiency as reflected in the Statement of deficiencies-form CMS-2567. However, all other current residents in the facility may have the potential to be affected by this deficiency, therefore; By 07/27/17, the Administrator/Abuse coordinator have been re-educated by the company COO, regarding F-225 with emphasis on the facility's abuse and neglect policy on the importance of: " Ensuring that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but no later than 2 hours after allegation is made if event that cause the allegation involve abuse result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to administrator of the facility and to other officials including Bureau of Facility Standards and in accordance to State and Federal Law. Investigation will need to be completed and submitted to the Bureau of Facility Standards within five (5) business day. By 07/28/17, Licensed Nurses will be re-educated by the Administrator or designee about F-225, on the importance in completing the Fall Scene Investigation Report and Occurrence Report with root caused analysis of the fall attached to the		

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F 225	Continued From page 4 interviewed Resident #8 the morning of 5/30/17 rather than 5/31/17. He said all resident-to-resident altercations must be reported and that he was unsure why the incident was not reported. 2. Resident #29 was admitted to the facility on 12/1/16 with multiple diagnoses, including dementia. The quarterly MDS assessment, dated 5/19/17, documented Resident #29 was cognitively impaired with physical and verbal behaviors. On 7/2/17 at 2:30 am, a Fall Scene Investigation Report documented Resident #29 was found unattended on the floor in her room. The Occurrence Report with root cause analysis of the fall was not attached to the investigation. The conclusion of the investigation by the IDT (Interdisciplinary Team) documented Resident #29 bent down toward the trash can and lost her balance. The daily assignment sheet, dated 7/2/17, documented CNA #5 was assigned to Resident #29 for 1:1 supervision on the night shift. On 7/12/17 at 2:00 pm, CNA #5 said h/she worked that night, but that another staff member was assigned as the 1:1 supervision for Resident #29. CNA #5 did not recall Resident #29's fall on 7/2/17. On 7/12/17 at 11:50 am, the DNS, when asked how Resident #29 fell on 7/2/17 when the daily assignment sheet had CNA #5 assigned as the 1:1 aide, stated the Occurrence Report and the	F 225	investigation. Measures that will be put into place or systemic changes to ensure that the deficient practice does not recur: To ensure that the deficiency practice does not recur, a root cause analysis was done by the Administrator, hence; On 07/27/17, a Reportable Incident/Accident Checklist Log, was formulated by the Administrator to be used by the Administrator starting 8/1/17 to ensure that reportable Incident(s)/Accident(s) are reported in a timely manner i.e. " No later than 2 hours after allegation is made if event that cause the allegation involve abuse result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to administrator of the facility and to other officials including Bureau of Facility Standards and in accordance to State and Federal Law. Investigation will need to be completed and submitted to the Bureau of Facility Standards within five (5) business day. On 07/27/17, the Administrator formulated a Checklist Log be used by the Administrator starting 8/1/17, to ensure completion of the Fall Scene Investigation Report and Occurrence Report with root cause analysis of fall(s) attached to the investigation. Monitoring will be done through:		

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F 225	Continued From page 5 investigation report was not completed to determine how Resident #29's fall occurred.	F 225	The DNS or designee will review sampling of at least 3 reportable Incident/Accident reports to ensure that reportable Incident(s)/Accident(s) are reported in a timely manner i.e. " no later than 2 hours after allegation is made if event that cause the allegation involve abuse result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to administrator of the facility and to other officials including Bureau of Facility. The DNS or designee will review sampling of at least 3 fall incident report(s) to ensure completion of the Fall Scene Investigation report and Occurrence Report with root cause analysis of fall(s) attached to the investigation. Monitoring will start on the week of 07/31/17. This will be done weekly X4, then q 2 weeks X4, then monthly X3. The DNS or designee will present to the monthly QA&A Committee monthly meeting the findings and/or corrective actions taken. Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee monthly meeting.		
F 281 SS=E	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility,	F 281			8/15/17

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F 281	Continued From page 6 as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, review of pharmacy records, and staff interviews, it was determined the facility failed to ensure pain medication was reordered for 1 of 7 sampled residents (#32) and that all licensed nurses could access - or knew who to contact for assistance accessing - emergency medications. This failure created the potential to compromise Resident #32's physical and psychosocial well-being, as well as that of any other resident who received pain medication on an as-needed basis to maintain comfort. Findings include: Resident #32 was admitted to the facility on 1/2/15 with diagnoses of psychosis, early onset dementia with behavioral disturbances, and chronic pain. A Care Plan, dated 10/4/16, documented Resident #32 experienced chronic pain and exhibited increased aggressive behaviors that may have been a sign of pain. A Physician's Order, dated 11/15/16, documented Resident #32 was to receive Norco 10/325 four times daily as needed for pain. A narcotic administration count sheet documented 60 tablets of Norco 10/325 were delivered to the facility on 4/19/17. Resident #32 received the last tablet of this delivery on 5/12/17 at 10:00 am. On 5/14/17 at 1:17 am, a Pharmacy Refill	F 281	F 281 483.21 (b)(3)(i) Services Provided Meet Professional Standards This facility does ensure that pain medication was reordered and that all licensed nurses could access-or knew who to contact for assistance accessing. Corrective action(s) accomplished for those residents found to have been affected by the deficient practice: Resident #32 pain medication had been re-ordered. Immediately when the company COO was notified by the LN regarding Resident # 32 pain medication, Pharmacy was immediately contacted by the company COO and pain medication was delivered. During that moment, there were also other License Nurses who have access to the emergency medication machine. Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken: Immediately when the company COO was notified by the LN regarding Resident # 32 pain medication, Pharmacy was		

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F 281	Continued From page 7 Request Order form was faxed to the pharmacy requesting 30 tablets of Norco 10/325 mg for Resident #32. The pharmacist delivered the medication to the facility at 2:00 am and it was administered to Resident #32 at 2:30 am, 35 hours after the last dose was administered on 5/12/17 at 10:00 am. On 7/13/17 at 2:00 pm, the pharmacist stated he provided the medication at 2:00 am on 5/14/17 as the resident was in pain, out of pain medication, and the nurse requesting the pain medication did not have access to the Pyxis. The pharmacist did not know why there was a delay in reordering the medication or why the nurse was not able to access the Pyxis for an emergency dose of Norco. The pharmacist produced an audit which documented there was an adequate amount of Norco in the Pyxis to treat Resident #32's pain for an extended time. On 7/13/17 at 2:45 pm, LN #2 stated she did not have access to the Pyxis since a new system was installed approximately 5 months before. On 7/13/17 at 2:55 pm, LN #4 stated she had access to the Pyxis, but there were times the new machine was "glitchy." She stated there had been numerous occasions when she could not access the Pyxis and that she would call the pharmacy at those times because no other staff in the facility could help new employees access Pyxis-stored medications. On 7/13/17 at 3:00 pm, the Director of Nursing Services (DNS) stated she was not aware of any problems with the Pyxis or that any licensed nurse could not access it. The DNS stated she	F 281	immediately contacted by the company COO and pain medication was delivered, and during that moment, there were also other License Nurses who have access to the emergency medication machine; although other current residents who are on pain medication in the facility may have the potential to be affected by this deficiency, therefore; By 07/28/17, the Administrator or designee and/or DNS or LN designee will do a one- time visual check on all resident(s) who are on pain medication to ensure that resident(s) have pain medication supply. By 07/28/17, the Administrator or designee and/or DNS or LN designee will do a one-time visual check to ensure that all License Nurses could access or knew who to contact for assistance accessing ☐ emergency medications. Immediately upon identification during the survey, aside from the License Nurse(s) having access to the emergency medication supply, a technical support contact number and a list of back-up emergency contact persons with access to the emergency medication supply was placed in the License Nurse's resource binder by the Administrator and DNS. Measures that will be put into place or systemic changes to ensure that the deficient practice does not recur: To ensure that the deficiency practice does not recur, a root cause analysis was done by the Administrator, hence;		

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OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCATELLO, ID 83201		
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F 281	Continued From page 8 and 2 other staff at the facility could correct issues and enter new staff into the system. On 7/13/17 at 5:00 pm, the DNS provided a list of 17 licensed nurses who could access the Pyxis. The list, completed by the DNS, documented 17 licensed nurses could access the system, including LN #2 and LN #4, however LN #3 and one random LN were not on the list. The DNS stated those two nurses would have access to the Pyxis that evening. On 7/13/17 at 6:30 pm, LN #3 stated that on 5/14/17 Resident #32 had "tears running down his face" because he was in pain. She stated Resident #32's Norco had not been refilled and she did not have access to the Pyxis. LN #3 stated she notified the facility on multiple occasions that she could not access Pyxis-stored medications and that other nurses she worked with were also unable to access the Pyxis.	F 281	By 07/28/17, the DNS or LN designee will provide an educational in-service to the facility License Nurses on F-281 regarding: " Emphasis on the importance ensuring that Resident(s) pain medication(s) are reordered. " Regarding the call list on who to contact and the procedures in the event of a licensed Nurses having trouble accessing the emergency medication machine (the technical support contact number and a list of back-up emergency contact persons with access to the emergency medication supply was placed in the License Nurse's resource binder by the Administrator and DNS). At least three (3) department heads Licensed Nurse have the ability to add a user (Licensed Nurses) to the emergency machine. Monitoring will be done through: " The DNS or LN designee will review sampling of at least 3 resident(s) who are on pain medication to ensure that resident(s) have pain medication supply. " The DNS or LN designee will review sampling of at least 3 License Nurses access to emergency medication; to ensure access or that the license nurse(s) knew who to contact for assistance accessing emergency medications. Monitoring will start on the week of 07/31/17. This will be done weekly X4, then q 2 weeks X4, then monthly X3. The DNS or LN designee will present to		

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F 281	Continued From page 9	F 281	the monthly QA&A Committee monthly meeting the findings and/or corrective actions taken. Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee monthly meeting.	8/15/17	
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on staff and resident interview, and record review, it was determined the facility failed to ensure residents were provided assistance with bathing. This was true for 3 of 10 residents (#4, #5, and #8) reviewed for hygiene and grooming. The lack of bathing could cause residents to experience embarrassment, isolation, decreased sense of self-worth, skin breakdown, or otherwise compromise their physical and/or psychosocial well-being. Findings include: 1. Resident #4 was admitted to the facility on 12/7/16 with multiple diagnoses, including dementia. A quarterly MDS (Minimum Data Set) assessment, dated 5/5/17, documented Resident #4 required extensive assistance from one staff member for bathing. A shower/bath tracking sheet for June 2017 documented Resident #4 was not showered or	F 312	F 312 §483.24 (a)(2) ADL Care Provided For Dependent Residents This facility does ensure that resident(s) were provided assistance with bathing. Corrective action(s) accomplished for those residents found to have been affected by the deficient practice: By 07/28/17, Resident #4, #5 and #8 bath schedule have been reviewed by the Administrator to ensure that assistance is provided with bathing. Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken: This deficiency is an isolated deficiency as reflected in the Statement of		

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F 312	Continued From page 10 bathed for 13 days from 6/9/17 to 6/22/17, nor for 7 days from 6/23/17 to 6/29/17. 2. Resident #5 was admitted to the facility on 9/9/14 with multiple diagnoses, including dementia. The annual MDS assessment, dated 6/28/17, documented Resident #5 required extensive assistance from 1 staff member for bathing. A shower/bath tracking sheet for April 2017 through July 2017 documented Resident #5 was not showered or bathed as follows: * 4/10/17 to 4/22/17 = 13 days * 5/7/17 to 5/12/17 = 6 days * 5/19/17 to 5/27/17 = 9 days * 6/1/17 to 6/13/17 = 13 days * 6/15/17 to 6/28/17 = 14 days * 6/29/17 to 7/3/17 = 5 days * 7/5/17 to 7/9/17 = 5 days 3. Resident #8 was admitted to the facility on 11/2/16 with multiple diagnoses, including paraplegia and muscle weakness. The 5/4/17 quarterly MDS assessment documented Resident #8 was cognitively intact and required extensive assistance of 1 staff for bathing and was cognitively intact. A shower/bath tracking sheet for May 2017 documented Resident #8 was not showered or bathed as follows: * 5/13/17 to 5/24/17 with a refusal on 5/18/17 = 12 days	F 312	deficiencies-form CMS-2567. However, all current residents may have the potential to be affected by this deficiency, therefore; By 07/28/17, the Administrator or designee will do one-time random unannounced visual observation to ensure that resident(s) scheduled for bathing are provided assistance with bathing. Measures that will be put into place or systemic changes to ensure that the deficient practice does not recur: To ensure that the deficiency practice does not recur, a root cause analysis was done by the Administrator, hence; By 07/28/17, the facility C.N.A.s will be provided with in-service education by the DNS or designee regarding F-312, with emphasis on the importance of ensuring that residents are provided assistance with bathing. Facility adopted a new Policy and Procedure regarding bathing and will be implementing and educating staff on approaches and technique that is being emphasize in the educational DVD "Bathing without a battle". Staff were educated on the importance of proper documentation on bathing, shower and bed bath in the resident individual record.		

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F 312	Continued From page 11 * 5/26/17 to 5/31/17 = 6 days A facility grievance for Resident #8, dated 5/30/17, documented some showers had not been provided due to newer staff who had not received correct oversight, but there had been no issues involving the provision of resident baths/showers since 5/30/17. The June 2017 shower/bath tracking sheet documented Resident #8 was not showered or bathed for 9 days from 6/2/17 to 6/10/17, nor for 10 days from 6/19/17 to 6/28/17. Resident #8's self-care deficit dressing and grooming care plan included a 6/20/17 intervention that documented, "If [Resident #8] chooses not to get up for a bath, give her a bed bath on her scheduled bath days and PRN [as needed]." On 7/11/17 at 10:30 am, Resident #8 said she had "never" refused a shower or bed bath and since she filed the grievance regarding her showers, the frequency of showers had improved. She said she was bathed once a week, but preferred to be bathed twice weekly. On 7/12/17 at 3:20 pm, the Director of Nursing (DNS) said she could not find a bathing policy related to frequency of baths or showers, but that she expected staff to make a second offer to those residents who initially refused a bath or shower. The DNS said residents should receive two-to-three showers/baths a week.	F 312	In addition to the regular scheduled C.N.A., Facility have scheduled Bath Aides to ensure residents are offered at least twice a week of their preference of bathing, shower or bed bath. Resident constant refusal per schedule or more than 3x consecutively will be refer to Social Service department to addresses any underlying issues. Monitoring will be done through: The facility Administrator or designee will do unannounced visual observation sampling of at least 3 resident(s) scheduled for bathing to ensure that resident(s) are provided assistance with bathing. Monitoring will start on 07/31/17. This will be done weekly X4, then q 2 weeks X4, then monthly X3. The Administrator or designee will present to the monthly QA&A Committee monthly meeting the findings and/or corrective actions taken. Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee monthly meeting.	8/15/17	
{F 323} SS=G	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	{F 323}			

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{F 323}	Continued From page 12 (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident and staff interview, it was determined the facility failed to provide adequate supervision to meet resident needs, and ensure a side rail was properly secured. This was true for 3 of 10 residents (#5, #8, and #29) reviewed for supervision and accidents. Resident #8 was harmed when staff failed to provide adequate assistance during incontinent cares and the resident fractured a hip when he/she fell out of bed. Resident #5 and #29 were at risk for harm	{F 323}	F 323 §483.25 (1)(2)(n)(1)-(3) Free of Accident Hazards/Supervision/Devices This facility does ensure that resident(s) were provided with adequate supervision to meet resident needs, and ensure a side rail was properly secured. Corrective action(s) accomplished for those residents found to have been		

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{F 323}	Continued From page 13 due to a lack of supervision to prevent falls, and Resident #8 was at risk for harm due to a loose bed side rail. Findings include: 1. Resident #8 was admitted to the facility on 11/2/16 with multiple diagnoses, including paraplegia, morbid obesity, and muscle weakness. a. The June 2017 Physician Orders, dated 11/2/16, documented Resident #8 was to be equipped with a bariatric bed with air overlay and bilateral half-siderails for comfort, protection, and mobility. The 5/4/17 quarterly Minimum Data Set assessment documented Resident #8 was cognitively intact and required extensive assistance of 2 staff for bed mobility and toileting. A mobility care plan, dated 5/8/17, included a 2/17/17 intervention that documented Resident #8 required 1-2 staff with bed mobility. The resident's urinary and bowel elimination care plan included a 5/8/17 intervention that documented Resident #8 was incontinent of bowel/bladder and required 2-3 staff assistance with toileting and cleansing. The resident's fall care plan, dated 5/8/17, documented a history of falling. The June 2017 Activities of Daily Living flow sheet documented Resident #8 was assisted every day from 6/1/17 to 6/14/16 by 2- or more staff with toileting and bed mobility. Resident #8's May 2017 Restorative Nursing Assistant goal assessment, dated 6/5/17, documented the resident required the assistance	{F 323}	affected by the deficient practice: Resident # 8, the C.N.A. # 1 assigned during the fall incident on 6/15/17, no longer works at this facility. Resident # 8 upper bilateral side rails to her bed will be observe by the Administrator or designee and/or the Maintenance Supervisor or designee to ensure that they are properly secured, by 07/28/17. Resident #5, the N.A. who was assigned to provide the 1:1 supervision during the fall incident on 06/27/17 was given a disciplinary action by a License Nurse and by the Assistant Administrator on 06/27/17. Resident # 29, fall investigation report that included the root cause analysis to determine the cause of the fall on 7/2/17, was completed on 07/12/17 by the facility DNS. The C.N.A who was assigned to provide the 1:1 supervision during the fall incident no longer works at the facility. Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken: All current resident(s) who are care planned for fall risk and who uses side rail(s) may have the potential to be affected by this deficiency, therefore;		

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{F 323}	Continued From page 14 of 2 staff members with bed mobility. A 6/15/17 Progress Note documented Resident #8 rolled out of bed at 5:15 am while receiving pericare from 1 Certified Nursing Assistant (CNA) and was sent to a local hospital. A hospital physician's note, dated 6/15/17, documented Resident #8 sustained a right hip fracture from the fall and was not a suitable candidate for surgical repair of the fracture. A Fall Scene Investigation, dated 6/15/17, documented the following: * Resident #8 had upper bilateral half side rails to her bed. At the time of the incident, CNA #1 was providing pericare from the resident's left side at the center of the bed and Licensed Nurse (LN) #1 was standing on the resident's right side near the head of the bed. * CNA #1's witness statement documented she performed pericare and when she tried to roll the resident back towards her, the resident began to slide off the bed. CNA #1 then yelled at LN #1 that the resident was sliding, but LN #1 did not attempt to stop the resident from sliding off the bed. * LN #1's witness statement documented she was standing on the opposite side of the bed from CNA #1 near Resident #8's head because she had just finished administering a medication when the resident's legs and body slipped off the bed at the same time CNA #1 yelled. LN #1 stated she could not stop the resident from sliding off the bed from where she was standing near the resident's head.	{F 323}	By 07/28/17, the Administrator or designee will do one-time unannounced visual observation to ensure that: - All current resident(s) who are care planned for fall risk are provided adequate supervision as care planned. - All current resident(s) who uses side rail(s) to ensure that side rails(s) are properly secured. Measures that will be put into place or systemic changes to ensure that the deficient practice does not recur: To ensure that the deficiency practice does not recur, a root cause analysis was done by the Administrator, hence; - Incident and accident report will be reviewed on the department morning meeting to ensure reports are completed timely, incident root cause have been identified and documented, incident intervention and appropriate actions have been implemented. - A facility "Fall Prevention Team," was established to review fall incident(s) and will be meeting weekly to ensure reports are completed timely, incident root cause have been identified and documented, incident intervention and appropriate actions have been implemented correctly and effective. - By 07/28/17, the facility Administrator or designee will be providing an in-service education to the Nursing Staff regarding F-323, with emphasis on the importance of ensuring that Resident(s) who are care		

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{F 323}	Continued From page 15 * Resident #8's witness statement documented she was on her right side with her left leg over the top of her right leg and was holding the side rail to her right side when she slipped off the bed. * The post-fall intervention called for staff education. Resident #8's falls care plan, dated 6/20/17, documented, "Always have at least two people when you are working with her. (She rolled off the bed when one person was assisting her by themselves [sic])," and "Make sure that her body is in the center of the bed at all times. If she is to [sic] close to the edge she may not be able to push herself back if she starts to go forward." The resident's hip fracture care plan, dated 6/28/17, documented, "Never position her or change her without having someone on each side of the bed." On 7/10/17 at 5:45 pm and throughout the survey, Resident #8 was observed in a bariatric bed with an alternating air mattress with foam edges and upper bilateral half-side rails, which stretched from the resident's head to her hips. On 7/11/17 at 10:30 am and 7/12/17 at 11:25 am, Resident #8 said the bed and side rails were the same as she had when the fall occurred. Resident #8 said there should have been two staff members assisting her with incontinent care prior to the 6/15/17 fall, but only CNA #1 assisted her and LN #1 did not enter the room until after CNA #1 had begun providing incontinent care. Resident #8 said CNA #1 was at her left near the center of the bed and LN #1 was talking to her at	{F 323}	planned for fall risk are provided adequate supervision as care planned. - By 07/28/17, the facility Administrator or designee will be providing an in-service education to the Maintenance Supervisor regarding F-323 with emphasis on importance of ensuring that side rail(s) are properly secured on Resident(s) who uses side rail(s). - A weekly "Side rails(s) Check Form," was created by the Administrator and Maintenance, to be used by the Maintenance Supervisor weekly, starting on the week of 7/31/17. Monitoring will be done through: - The facility Administrator or designee will do unannounced visual observation sampling of at least 3 Resident(s) who are care planned for fall risk to ensure that adequate supervision is provided as care planned. - The facility Administrator or designee will do unannounced visual observation sampling of at least 3 Resident(s) who uses side rail(s) to ensure that side rails(s) are properly secured. Monitoring will start on the week of 07/31/17. This will be done weekly X4, then q 2 weeks X4, then monthly X3. The Administrator or designee will present to the monthly QA&A Committee monthly meeting the findings and/or corrective actions taken.		

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{F 323}	Continued From page 16 the head of the bed on her right side, when she started to slip off the bed. Resident #8 stated she grabbed the bed side rail on her right and said, "I'm falling." She said LN #1 put her hands up in the air and backed away from the resident's bed as the resident started to fall. Resident #8 said she tried to hold onto the side rail, but it was loose and she could not stop her fall. She said when she was on the floor and in pain, LN #1 told her she (LN #1) should have tried to help the resident from falling. On 7/12/17 at 8:35 am, and at 9:30 am, CNA #2 and CNA #3 respectively said Resident #8 required the assistance of 2 for incontinent care prior to the 6/15/17 fall. On 7/12/17 at 1:25 pm and 2:10 pm, LN #1 said CNA #1 was already providing incontinent care for Resident #8 when LN #1 entered the resident's room. LN #1 said she should have stood next to the resident's bed near the center, but was located at the head of the bed where she provided a medication to the resident, and then started talking to Resident #8 while CNA #1 continued providing incontinent care by herself. LN #1 said she heard the resident scream and grab the side rail and LN #1 tried to move to stop the resident from sliding off the bed, but it had happened too quickly for her to block the resident from falling to the floor. LN #1 said after the fall, CNA #1 told her she knew Resident #8 required 2 staff members with incontinent care, but she had not asked for help. On 7/12/17 at 3:20 pm, the Director of Nursing Services (DNS) reviewed Resident #8's incontinent care plan and the fall scene	{F 323}	Governing Body designee will audit incident and accident report weekly X4, then q 2 weeks X4, then monthly X3 to ensure reports are completed timely, incident root cause have been identified and documented, incident intervention and appropriate actions have been implemented correctly and effective. All QA results and audits will be reviewed in the quarterly governing body meeting. Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee monthly meeting.		

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NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO				STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCATELLO, ID 83201			
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{F 323}	Continued From page 17 investigation and said there should have been at least 2 staff members providing incontinent care rather than CNA #1 performing it on her own. She said LN #1 was at the head of bed when the resident fell and not near the center of the bed to help prevent the resident from slipping out of the bed. Resident #8 was harmed when she fell out of bed during incontinent care and sustained a fracture to the right hip. The facility did not provide incontinent care on 6/15/17 as care planned. b. Resident #8's 5/8/17 and 6/28/17 side rail evaluations documented the resident used side rails for bed mobility. Resident #8's July 2017 Physician Orders, dated 6/19/17, documented the bed was to be equipped with bilateral half side rails for bed mobility. Resident #8's mobility care plan, dated 6/20/17, documented bilateral half side rails were needed for mobility and positioning. A Maintenance Work Request, dated 6/20/17, documented Resident #8's side rails were not stable and that staff was to "tighten down [the] rail as much as they would allow." On 7/11/17 at 10:30 am, Resident #8's bilateral half bed side rails were observed to be loose. The bed rail to the resident's right moved horizontally and vertically one-inch in each direction and the bed rail to the resident's left moved a half-inch in each direction. Resident #8 grabbed the right side rail and said it was "loose"			{F 323}			

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{F 323}	Continued From page 18 and maintenance had been in a few weeks prior and tried to tighten it, but it was still loose. She said she was concerned because during a fall on 6/15/17, she grabbed that rail and it was now looser than before the fall. She said she "could not trust" the bed rails to help with her mobility needs when she used them. On 7/13/17 at 10:45 am, the Maintenance Supervisor observed Resident #8's bed rails and said the bed rail to the resident's right side was looser than the other side. He said the rails were safe for the resident, but the way the resident grabbed the side rail may make it more difficult to use due to the movement of the rail. 2. Resident #5 was admitted to the facility on 9/9/14 with multiple diagnoses, including dementia and history of falls. The annual MDS assessment, dated 6/28/17, documented Resident #5 was cognitively impaired, had an unsteady gait, and required extensive staff assistance with all ADLs (Activities of Daily Living). On 6/27/17 at 12:45 pm, a facility Occurrence Report documented Resident #5 was found on the floor of her room. The report documented the root cause of the fall as "1:1 [one-to-one] staffing left, not in arms reach ... staff in wrong place, counsel done". The 1:1 Shift Report, dated 6/27/17 at 11:41 am, documented, "[Resident #5] was sleeping then staff went out to smoke, Resident #5 fell and was crawling out the door."	{F 323}			

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{F 323}	Continued From page 19 The daily assignment sheet, dated 6/27/17, documented NA (Nursing Aide) #1 was assigned to Resident #5 for 1:1 supervision on the day shift. On 7/13/17 at 12:00 pm, NA #1 said, h/she had to go to the bathroom and asked another CNA to listen for Resident #5's alarms. NA #1 said h/she forgot to turn on the alarm and was educated not to leave Resident #5 out of "arms length." NA #1 said Resident #5 would not have fallen if h/she had not left the resident without 1:1 supervision. On 7/10/17 at 3:00 pm, the facility provided a list of seven residents who required 1:1 supervision. On 7/10/17 at 5:30 pm, Resident #5 was observed in bed sleeping with a 1:1 aide within "arms length" next to her. Resident #5's bed was in the lowest position with alarms and floor mat in place. On 7/11/17 at 9:35 am, CNA #4 was observed sitting next to Resident #5 while the resident was sleeping. CNA #4 said she was educated to be within "arms length" when assigned as the 1:1 aide. On 7/13/17 at 4:30 pm, LSW #1 said, Resident #5 was assigned to have 1:1 supervision at all times due to being a high fall risk and poor safety awareness. LSW #1 said the IDT (Interdisciplinary Team) met daily to discuss the continued need for 1:1 supervision. 3. Resident #29 was admitted to the facility on 12/1/16 with multiple diagnoses, including	{F 323}			

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{F 323}	Continued From page 20 dementia. The quarterly MDS assessment, dated 5/19/17, documented Resident #29 was cognitively impaired with physical and verbal behaviors. On 7/2/17 at 2:30 am, a Fall Scene Investigation Report documented Resident #29 was found unattended on the floor of her room. An Occurrence Report with the root cause of the incident was not attached to the investigation. The conclusion of the IDT investigation documented Resident #29 bent down toward the trash can and lost her balance. The 7/2/17 daily assignment sheet documented CNA #5 was assigned to provide Resident #29 with 1:1 supervision on the night shift. On 7/12/17 at 2:00 pm, CNA #5 said h/she worked the 7/2/17 night shift, but was not assigned to provide 1:1 supervision for Resident #29. On 7/12/17 at 11:50 am, when asked about the 7/2/17 daily assignment sheet documenting CNA #5 provided 1:1 night shift supervision to Resident #29 and the resident's fall that night, the DNS stated the investigation into the resident's fall had not been completed and the cause had not yet been determined.	{F 323}			
{F 328} SS=D	483.25(b)(2)(f)(g)(5)(h)(i)(j) TREATMENT/CARE FOR SPECIAL NEEDS (b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must:	{F 328}			8/15/17

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{F 328}	Continued From page 21 (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments (f) Colostomy, ureterostomy, or ileostomy care. The facility must ensure that residents who require colostomy, ureterostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. (g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to ... prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. (h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. (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	{F 328}			

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{F 328}	Continued From page 22 comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. (j) Prostheses. The facility must ensure that a resident who has a prosthesis is provided care and assistance, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, to wear and be able to use the prosthetic device. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure staff changed residents' oxygen tubing and cannula as ordered by the physician. This was true for 1 of 5 residents (#4) reviewed for oxygen therapy and created the potential for respiratory infections due to the growth of pathogens in the tubing and cannulas. Findings include: 1. Resident #4 was admitted to the facility on 12/7/16 with multiple diagnoses, including anxiety and COPD (Chronic Obstructive Pulmonary Disease). Resident #4's quarterly MDS assessment, dated 5/5/17, documented the resident received oxygen therapy. Resident #4's Physician Orders, dated 7/4/17, documented staff was to change the oxygen tubing the first day of every month and as needed during night shift. Resident #4's July's 2017 MAR (Medication	{F 328}	F 328 §483.25 (b)(2)(f)(g)(5)(h)(i)(j) Treatment/Care for Special Needs This facility does ensure that staff changed residents' oxygen tubing and cannula as ordered by the physician. Corrective action(s) accomplished for those residents found to have been affected by the deficient practice: Resident # 4 Oxygen tubing was replaced on 7/13/17 and was replace again on 8/1/17. Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken: This deficiency is an isolated deficiency as reflected in the Statement of deficiencies-form CMS-2567. However, all other current residents who have		

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{F 328}	Continued From page 23 Administration Record) did not document Resident #4's oxygen tubing was changed on 7/1/17 per physician order. On 7/10/17 at 5:45 pm, Resident #4 was observed wearing oxygen tubing that was connected to a portable oxygen tank on her wheelchair. The oxygen tubing had not been dated. On 7/11/17 at 9:30 am, Resident #4 was observed wearing oxygen tubing connected to a portable oxygen tank on her wheelchair. There was no date documented on the oxygen tubing. On 7/11/17 at 4:00 pm, the DNS stated Resident #4's July 2017 MAR did not have a signature documenting the oxygen tubing was changed on 7/1/17. The DNS observed Resident #4's oxygen tubing was not dated and stated nursing staff should have changed the oxygen tubing on 7/1/17 and documented the change on the resident's July 2017 MAR.	{F 328}	physician's order to change oxygen tubing as ordered may have the potential to be affected by this deficiency, therefore; All resident's oxygen tubing was audited by the central supply staff to ensure oxygen tubing were replaced monthly. All resident Oxygen tubing were replace on 8/1/17. Measures that will be put into place or systemic changes to ensure that the deficient practice does not recur: To ensure that the deficiency practice does not recur, a root cause analysis was done by the Administrator, hence; Central supply staff will be auditing oxygen tubing weekly to ensure oxygen tubing were replaced monthly and as needed. Record of this inspection in being kept it the central supply office and a copy will be given to the Administrator. By 07/28/17, the facility Administrator or designee will be providing an in-service education to the License Nurses Staff regarding F-323, with emphasis on the importance of making sure Resident(s) who have physician's order to change oxygen tubing, that the oxygen tubing is changed and dated, as ordered. Monitoring will be done through:		

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{F 328}	Continued From page 24	{F 328}	The facility Administrator or designee will do unannounced random inspection and audit on residents oxygen tubing, to ensure that oxygen tubing is changed and dated as ordered. Monitoring will start on the week of 07/31/17. This will be done weekly X4, then q 2 weeks X4, then monthly X3. The Administrator or designee will present to the monthly QA&A Committee monthly meeting the findings and/or corrective actions taken. Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee monthly meeting.		
{F 441} SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (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: (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 (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not	{F 441}		8/15/17	

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{F 441}	Continued From page 25 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 infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.			{F 441}			

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{F 441}	Continued From page 26 (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (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 observation, record review, and resident and staff interview, it was determined the facility failed to implement infection control measures alerting those entering a resident's room of an infectious disease and to provide education to all staff members regarding isolation precautions. This was true for 1 of 10 residents (#3) reviewed for infection control and had the potential to harm if Clostridium difficile (C-diff) were to spread in the facility from improper infection control procedures. Findings include: The facility's isolation precaution policy, dated January 2012, documented signs were to be placed to alert staff and visitors of active infection precautions for any resident placed under such precautions, including those diagnosed with C-diff. Resident #3 was readmitted to the facility on 6/27/17 with multiple diagnoses, including C-diff. Physician Orders, dated 6/26/17, documented Resident #3 did not want antibiotic treatment. Resident #3's physician admission orders, dated 6/27/17, directed the facility to initiate standard precautions for C-diff.			{F 441}	F 44 §483.80 (a)(1)(2)(4)(e)(f) Infection Control, Prevent Spread, Linens This facility does ensure that infection control measures alerting those entering a resident's room of an infectious disease is implemented and that education to members regarding isolation precautions is provided. Corrective action(s) accomplished for those residents found to have been affected by the deficient practice: Resident # 3, upon identification during the survey process, the signage to alert staff and visitor of active infection control precaution(s) was put back on the door. Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken: This deficiency is an isolated deficiency as reflected in the Statement of deficiencies-form CMS-2567. However, all other current residents who		

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{F 441}	Continued From page 27 Resident #3's June and July 2017 Treatment Administration Record documented C-diff precautions were in place. Resident #3's lab results, dated 7/10/17, documented the resident continued to test positive for C-diff. Resident #3's Contact Isolation care plan, dated 7/10/17, documented the resident had contact isolation precautions and measures in place. From 7/10/17 at 2:55 pm to 7/13/17 at 9:55 am, Resident #3's door and room were observed on six different occasions. The door displayed a hanging storage container with personal protection equipment, including, disposable gloves, masks, and red and yellow colored trash bags; there was no signage on or near the door related to isolation precautions. Just inside the room were two trash receptacles lined with red and yellow colored trash bags and a small table with disposable gowns. On 7/10/17 at 3:00 pm, LN #5 said any staff or visitors going into Resident #3's room were required to wear gowns, masks, and gloves. On 7/10/17 at 5:38 pm, Certified Nurse Assistant #6 (CNA) observed Resident #3's door and said only those giving care were required to wear gowns, gloves and masks. On 7/11/17 at 2:52 pm, CNA #7 observed Resident #3's door and said staff were to wear gowns, masks and gloves when going into the room, but she did not know what visitors should do if they went into the room.	{F 441}	are on isolation precaution may have the potential to be affected by this deficiency, therefore; By 07/28/17, the Administrator or designee will do one-time unannounced visual observation on Resident(s) who are on isolation precaution, to ensure that the signage for isolation precaution is placed on the Resident(s) door. Measures that will be put into place or systemic changes to ensure that the deficient practice does not recur: To ensure that the deficiency practice does not recur, a root cause analysis was done by the Administrator, hence; By 07/28/17, the facility Administrator or designee will be providing an in-service education to the License Nurses regarding F-441, with emphasis on the importance of making sure Resident(s) who are on isolation precaution, to ensure that the signage for isolation precaution is placed on the Resident(s) door. By 07/28/17, the facility Administrator or designee will be providing an in-service education the facility staff regarding F-441 with emphasis on isolation precaution(s). Monitoring will be done through: The facility Administrator or designee will do unannounced visual observation on all Resident(s) who are on isolation		

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NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCA TELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCA TELLO, ID 83201		
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{F 441}	Continued From page 28 On 7/13/17 at 9:55 am, the Director of Nursing Services (DNS) observed Resident #3's door and said there had been a sign on the door the previous week, but there was no longer a sign to alert visitors to check with the nurse before entering the resident's room. The DNS said no staff or visitor should go into the room without wearing a gown, mask and gloves.	{F 441}	precaution, to ensure that the signage for isolation precaution is placed on the Resident(s) door. Monitoring will start on the week of 07/31/17. This will be done weekly X4, then q 2 weeks X4, then monthly X3. The Administrator or designee will present to the monthly QA&A Committee monthly meeting the findings and/or corrective actions taken. Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee monthly meeting.		
F 463 SS=D	483.90(g)(2) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH (g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area - (2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, review of maintenance audits, and staff interviews, it was determined the facility failed to ensure all call lights were functioning. This was true for 1 of 1 (#31) random resident and had the potential for harm if residents were unable to summon staff assistance by activating the call light. Findings include:	F 463	F 463 483.90 (g)(2) Resident Call System-Rooms/Toilet/Bath This facility does ensure that Residents call lights are functioning Corrective action(s) accomplished for		8/15/17

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F 463	Continued From page 29 On 7/10/17 at 3:00 pm, Resident #31 said her call light did not work and that she had notified the Maintenance Supervisor when the call light first became inoperable about a month prior. Resident #31 was observed pushing the red button on the call light, which failed to activate either the light inside or outside the room. On 7/11/17 at 10:15 am, Resident #31 was observed pushing the red button on the call light, which was still was not working. On 7/12/17 at 9:15 am, the Maintenance Supervisor said he performed weekly call light audits and that he was unaware that Resident #31's call light did not work. The Maintenance Supervisor was observed pushing the call light and said it was not activating the light inside or outside of the room. The facility's computer system did not indicate a call light failure for Resident #31's room. The Maintenance Supervisor examined the cord, which he said was not working, and replaced the cord. On 7/13/17 at 3:10 pm, the Maintenance Supervisor and COO (Chief of Operations) provided the weekly call light audits, dated 5/26/17 through 7/11/17. On 7/11/17, the audit documented Resident #31's room call light was functioning. The Maintenance Supervisor said when auditing the call lights, he checked the bathroom and one bed call light and if both functioned then he would not check the call light belonging to the other bed in the room.	F 463	those residents found to have been affected by the deficient practice: Resident # 31, upon identification during the survey process the call light cord that was not working was replaced by the Maintenance Supervisor. Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken: This deficiency is an isolated deficiency as reflected in the Statement of deficiencies-form CMS-2567. However, all other current residents who uses call lights may have the potential to be affected by this deficiency, hence; The facility call light system provider was contacted by the facility to diagnose and fix if necessary, call light system provider came in on 07/24/17. The next day after, on 07/25/17, the Administrator and Maintenance Supervisor did check all the call lights and deemed that facility call lights were 100% operational. Measures that will be put into place or systemic changes to ensure that the deficient practice does not recur: To ensure that the deficiency practice does not recur, a root cause analysis was done by the Administrator, hence; By 07/28/17, the facility Administrator or designee will be providing an in-service education to the Maintenance Supervisor		

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F 463	Continued From page 30	F 463	regarding F-463 with emphasis on the importance of making sure that when a Resident notified him about call light not working, to make sure that the call light is fix timely. Monitoring will be done through: The facility maintenance department will ensure all call light system and equipment are working. Aside from the computer generated report, maintenance department will do physical rounds and test call lights hand control to ensure hand control is working. The facility Administrator or designee will do unannounced visual observation of at least 3 Resident(s) who uses call light to ensure that call light is working. Monitoring will start on the week of 07/31/17. This will be done weekly X4, then q 2 weeks X4, then monthly X3. The Administrator or designee will present to the monthly QA&A Committee monthly meeting the findings and/or corrective actions taken. Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee monthly meeting.		
{F 520} SS=F	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a	{F 520}		8/15/17	

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{F 520}	Continued From page 31 minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record review, review of the facility's compliance history, and staff interview, it was			{F 520}	F 520		

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{F 520}	Continued From page 32 determined the facility's Quality Assessment and Assurance (QAA) committee failed to make corrections and resolve systemic deficiencies. This was true for 5 of 10 sampled residents (#3, #4, #5, #8 and #29) and 1 random resident (#31). This failure resulted in the QAA committee providing insufficient direction and control necessary to ensure residents' quality of care needs were met and created the potential to harm all residents due to insufficient and/or inadequate care. Findings included: The QAA committee failed to provide sufficient monitoring and oversight to sustain regulatory compliance as evidenced by the following citations from the 3/23/17 complaint survey and the 7/23/17 on-site follow up survey to the complaint survey. 1. The facility failed to maintain compliance since the alleged compliance date of 6/12/17 from the facility's 3/23/17 complaint survey for F323, F328, F441, and F520. 2. The facility failed to provide appropriate supervision and fall prevention for residents and was recited at F323. The facility was cited at F323 on the five previous recertification and/or complaint surveys conducted 6/19/15, 4/15/16, 7/15/16, 3/23/17, and 7/13/17. 3. The facility failed to change oxygen tubing and cannula's monthly for residents and was recited at F328. 4. The facility failed to provide infection control precautions and was recited at F441.	{F 520}	§483.75 (g)(1)-(iii)(2)(i)(ii)(h)(i) QAA Committee-Members/Meet Quarterly/Plans This facility does ensure to make corrections and resolve systemic deficiencies Corrective action(s) accomplished for those residents found to have been affected by the deficient practice: 1. The facility submitted a plan of correction for an allegation of compliance with regards to the complaint survey under F-323, F-328, F-441, and F-520 with compliance date of 8/15/17. 2. The facility submitted a plan of correction for an allegation of compliance with regards to appropriate supervision and fall prevention for residents, please reference to allegation of compliance F-323 for plan of correction. 3. The facility submitted a plan of correction for an allegation of compliance with regards to changing of oxygen tubing as ordered by the physician, please reference to allegation of compliance F-328 for plan of correction. 4. The facility submitted a plan of correction for an allegation of compliance with regards to providing infection control precautions, please reference to allegation of compliance F-441 for plan of correction.		

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{F 520}	Continued From page 33 5. The facility failed to make corrections and resolve systemic problems through its Quality Assessment and Assurance process. On 7/13/17 at 5:10 pm, the Administrator with the DNS present, said lack of staffing was the root cause for many previous deficiencies.			{F 520}	5. The facility QA&A Committee will incorporate in their monthly scheduled meeting, the facility the plan of correction(s) review, to ensure compliance. Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken: All current residents may have the potential to be affected by this deficiency, hence; The Administrator or designee is submitting these plan of correction(s), for an allegation of compliance: Please reference to allegation of compliance (F-323, F-328, F-441, and F-520) plan of corrections. Measures that will be put into place or systemic changes to ensure that the deficient practice does not recur: To ensure that the deficiency practice does not recur, a root cause analysis was done by the Administrator, hence, QA&A Committee meetings will be scheduled on a monthly basis. Therefore, on the next scheduled monthly QA&A committee meeting, the facility the plan of correction(s) will also be reviewed, to ensure compliance. Please reference to allegation of compliance plan of		

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{F 520}	Continued From page 34	{F 520}	corrections under "Measures," on F-Tags (F-323, F-328, F-441, and F-520). Monitoring will be done through: Please reference to allegation of compliance plan of corrections under "Monitoring," on F-Tags (F-323, F-328, F-441, and F-520). Monitoring will start on the week of 07/31/17. This will be done weekly X4, then q 2 weeks X4, then monthly X3. QA&A Committee during their monthly meeting will discuss the findings and/or corrective actions taken to ensure compliance. Monthly findings and/or corrective actions taken by the QA&A Committee team will be discussed to the Governing Body meeting. Governing Body designee will audit incident and accident report weekly X4, then q 2 weeks X4, then monthly X3 to ensure plan of corrections for all citations were implemented correctly and effective. Monthly findings and/or corrective actions taken by the QA&A Committee team will be discussed to the Governing Body meeting. Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee monthly meeting.		

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C 000	16.03.02 INITIAL COMMENTS A follow-up survey and a complaint investigation survey was conducted at the facility from July 10, 2017 to July 13, 2107. The surveyors conducting the survey were: Jenny Walker, RN, Team Coordinator Brad Perry, LSW Edith Cecil, RN Cecilia Stockdill, RN Abbreviations: RN = Registered Nurse	C 000		
C 762	02.200,02,c,ii When Average Census 60-89 Residents ii. In SNFs with an average occupancy rate of sixty (60) to eighty-nine (89) patients/residents a registered professional nurse shall be on duty for each a.m. shift (approximately 7:00 a.m. - 3:00 p.m.) and p.m. shift (approximately 3:00 p.m. to 11:00 p.m.) and no less than a licensed practical nurse on the night shift. This Rule is not met as evidenced by: Based on review of nursing schedules from 6/12/17 through 7/11/17, it was determined the facility did not provide RN (Registered Nurse) coverage when the resident occupancy rate was between 60 and 89 residents for each of the days reviewed. Inadequate RN coverage had the potential to negatively affect all residents who may have required cares only a Registered	C 762	C 762 02.200,02,c,ii When Average Census 60-89 Residents This facility does ensure to provide RN (Registered Nurse) coverage when the resident occupancy rate is between	8/15/17

Bureau of Facility Standards

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

TITLE

(X6) DATE

Electronically Signed

08/01/17

Bureau of Facility Standards

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C 762	Continued From page 1 Nurse was licensed to provide. Findings include: The facility's nursing schedule from 6/12/17 through 7/11/17 specific to RN coverage documented there were no RNs working on the Day and/or Evening Shift during the following: * 6/13/17 (2:00 pm - 6:00 pm) - Resident census = 69. * 6/17/17 (6:00 am - 2:00 pm) - Resident census = 67. * 6/20/17 (2:00 pm - 6:00 pm) - Resident census = 69. * 6/21/17 (6:00 am - 2:00 pm) - Resident census = 69. * 6/22/17 (2:00 pm - 6:00 pm) - Resident census = 69. * 6/27/17 (3:30 pm - 6:00 pm) - Resident census = 71. * 6/28/17 (6:00 am - 2:00 pm) - Resident census = 73. * 6/29/17 (2:00 pm - 6:00 pm) - Resident census = 72. * 7/2/17 (10:00 am - 10:00 pm) - Resident census = 74. * 7/4/17 (2:00 pm - 6:00 pm) - Resident census = 75. * 7/5/17 (6:00 am - 5:00 pm) - Resident census = 73. * 7/6/17 (3:00 pm - 9:30 pm) - Resident census = 75. * 7/7/17 (6:00 am - 8:00 pm) - Resident census = 75. * 7/8/17 (6:00 pm - 10:00 pm) - Resident census = 75. * 7/9/17 (6:00 pm - 10:00 pm) - Resident census = 75. * 7/11/17 (2:00 pm - 6:00 pm) - Resident census = 75.	C 762	60-89. Corrective action(s) accomplished for those residents found to have been affected by the deficient practice: All residents may have the potential to be affected by this deficiency, hence; Facility will schedule adequate RN (Registered Nurse) hours for resident occupancy rate of between 60-89. Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken: All residents may have the potential to be affected by this deficiency, hence; Facility will schedule adequate RN (Registered Nurse) hours for resident occupancy rate of between 60-89. By 07/28/17, the facility Administrator or designee and/or the DNS or designee will review the current facility License Nurses schedule for RN (Registered Nurse) coverage. The facility will continue to advertisement and recruit for RN (Registered Nurse) on Indeed.com, department of labor, craig's list, KSL, facebook page and upcoming job fairs in the area and all surrounding areas. Measures that will be put into place or	

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C 762	Continued From page 2 On 7/13/17 at 9:30 am, the Administrator and Director of Nursing Services were unable to provide documentation of RN coverage for the shifts above.	C 762	systemic changes to ensure that the deficient practice does not recur: To ensure that the deficiency practice does not recur, a root cause analysis was done by the Administrator, hence; By 07/28/17, the facility DNS or designee will be reviewing the weekly License Nurses schedule for RN (Registered Nurse) coverage. The facility will continue to advertisement and recruit for RN (Registered Nurse) on Indeed.com, department of labor, craig's list, KSL, facebook page and upcoming job fairs in the area and all surrounding areas. Aside from department head RN will be scheduled if needed, the facility will utilized a staffing agency RN when RN coverages are needed. Monitoring will be done through: The facility Administrator or designee will do unannounced visual review of the current License Nurses schedule for RN (Registered Nurse) coverage when the resident occupancy rate is between 60-89. Monitoring will start on the week of 07/31/17. This will be done weekly X4, then q 2 weeks X4, then monthly X3. The Administrator or designee will present to the monthly QA&A Committee monthly	

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C 762	Continued From page 3	C 762	meeting the findings and/or corrective actions taken. Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee monthly meeting.	



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RUSSELL S. BARRON – Director

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
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September 21, 2017

Darwin Royeca, Administrator
Safe Haven Care Center of Pocatello
1200 Hospital Way
Pocatello, ID 83201-2708

Provider #: 135071

Dear Mr. Royeca:

On **July 13, 2017**, an unannounced on-site complaint survey was conducted at Safe Haven Care Center of Pocatello. The complaint was investigated in conjunction with the facility's on-site Complaint follow-up survey conducted July 10, 2017 through July 13, 2017.

Residents were observed for physical therapy and range of motion services, fall precautions, bathing and grooming, incontinent care, activity spaces, and resident-to-resident altercations. Call lights, meal trays, medication pass, noise levels, and a test tray were also observed.

The clinical record of the identified resident and nine other residents' records were reviewed for Quality of Care and Quality of Life concerns. The facility's Grievance file was reviewed, as well as its Incident and Accident reports, abuse policy, abuse allegations, and staffing reports.

Several residents, Certified Nursing Assistants (CNA), and nurses were interviewed regarding various Quality of Care and Quality of Life issues. The Certified Dietary Manager, Maintenance Supervisor, Social Worker, and Restorative Nurses Assistant (RNA) were interviewed, as well as the Director of Nursing Services and Administrator regarding various issues.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007552

ALLEGATION #1:

The Reporting Party said an identified resident did not receive therapy services to help with walking or transfers.

FINDINGS:

An identified resident was observed receiving Range of Motion (ROM) services, as well as four other residents who either received Physical Therapy or ROM, and no concerns were identified.

An identified resident's clinical record and four other residents' records included documentation that each resident received the appropriate level of therapy based on their clinical condition.

An identified resident said the Restorative Nurse Aide provided services, and expressed a desire for more intensive therapy, which was not possible as the resident had experienced a recent fall with fracture. The Restorative Nurse Aide and Director of Nursing Services said the identified resident received the appropriate amount of ROM services and was currently not a candidate for physical therapy.

Based on observation, record review, and resident and staff interview, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The facility did not provide adequate information to other nursing facilities to assist an identified resident's transfer to one of those facilities.

FINDINGS #2:

The identified resident's clinical record documented the facility worked to transfer the resident to other facilities per the resident's request.

An identified resident said one of the facilities contacted was sending a representative to talk with him/her in the next couple of days and to evaluate the resident's situation. The Social Worker said at least six facilities had been contacted, but had not accepted the resident. The Social Worker stated the facility was still working to help the resident relocate to a facility of his/her liking.

Based on record review, and resident and staff interview, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

An identified resident did not receive adequate showers.

FINDINGS #3:

Based on record review, and resident and staff interview, it was determined the allegation was substantiated and the facility was cited at F312. Please refer to federal 2567 report for details.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #4:

An identified resident was assaulted by another resident and thought it may happen again.

FINDINGS:

Based on record review, and resident and staff interview, the allegation was substantiated and the facility was cited at F225. Please refer to federal 2567 report for details.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #5:

The facility did not provide adequate supervision for an identified resident when he/she fell and sustained a hip fracture.

FINDINGS:

Based on observation, record review, and resident and staff interview, it was determined the

allegation was substantiated and the facility was cited at F323. Please refer to federal 2567 report for details.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #6:

Staff discounted an identified resident's account of a fall.

FINDINGS #6:

An Incident and Accident report for the identified resident presented no concerns regarding the resident's statement. Several other Incident and Accident reports were reviewed for residents' statements and no concerns were identified.

An identified resident relayed the account of a fall incident, which matched the written report. The Director of Nursing Services said the identified resident's witness statement was documented accurately.

Based on record review, resident and staff interview, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #7:

Call lights were not working and not answered in a timely manner.

FINDINGS #7:

Based on observation, record review, and resident and staff interview, it was determined the allegation was substantiated and the facility was cited at F463. Please refer to federal 2567 report for details.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #8:

Room tray meals were served cold and dining room trays were served late.

FINDINGS:

Several meals were observed in all three dining rooms and no concerns were identified. A test tray was assessed at a palatable temperature.

Several residents said they had no concerns with late meal service or food temperature. The Certified Dietary Manager said meals were served as quickly as possible, were at the right temperature, and the test meal was flavorful.

Based on observations, a test tray, and resident and staff interview, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #9:

Residents were left sitting in their wheelchairs with soiled incontinent briefs for long periods of time due to lack of staff.

FINDINGS #9:

Similar allegations were investigated during a complaint survey from March 23, 2017 and the facility was cited at F241 and F353. Please refer to complaint survey results regarding these deficient practices on the federal 2567 report.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #10:

There were no public spaces for residents to gather and socialize, except for the dining room which required staff to be present. Staff were not available to socialize with residents.

FINDINGS #10:

Throughout the survey, residents were observed gathered in the facility's main entrance foyer, patios, TV room outside of therapy, and in the three dining rooms.

Several residents, staff members, and the Director of Nursing Services said there were other places where residents could congregate and socialize, including the main entrance foyer, patios, the TV room outside of therapy and in the three dining rooms.

Based on observation, and resident and staff interview, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #11:

An identified resident's medications were not administered in a timely manner and overlapped, making the resident sick.

FINDINGS #11:

Several residents' medications were observed to be delivered in a timely manner.

An identified resident and two other residents' clinical records were reviewed and no medication administration issues were identified.

An identified resident said medication delivery was no longer a concern. Several nurses said medications were given as ordered by the physician. The Director of Nursing Services said she, the physician, and the pharmacist had been working together on solutions to hasten medication pass delivery.

Based on observation, record review, and resident and staff interview, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #12:

The facility is extremely noisy.

FINDINGS #12:

Noise in the facility were observed throughout survey and no concerns were identified.

Several residents said there were no concerns with noise levels and when other residents yelled or acted out, staff were quick to address those residents' needs. The Director of Nursing Services said since the facility's staff levels had increased, residents who acted out were much calmer, which created a quieter environment for all residents.

Based on observations, and resident and staff interview, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #13:

A diagnostic lab level was high for a medication an identified resident had not used for several years.

FINDINGS #13:

An identified resident's clinical record was reviewed and an admission lab result documented a high level for a medication.

An identified resident said the lab result in question was high, but the current facility was not at fault and he/she must have received the medication without his/her knowledge from a different health care facility.

Based on record review and resident interview, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

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ALLEGATION #14:

The facility does not have enough nurses to assist residents.

FINDINGS #14:

Based on record review, and resident and staff interview, the allegation was substantiated and the facility was cited at C762. Please refer to federal 2567 report for details.

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 questions, comments or concerns regarding our investigation, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

A handwritten signature in dark ink that reads "D. Scott". The "D" is stylized with a vertical line through it, and "Scott" is written in a cursive-like script.

DAVID SCOTT, R.N., Supervisor
Long Term Care

DS/lj