IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

CERTIFIED MAIL: 7007 0710 0002 7979 1984

February 9, 2009

Brian V. Sawyer, Administrator
Aspen Park Healthcare
420 Rowe Street
Moscow, ID 83843

Provider #: 135093

Dear Mr. Sawyer:

On **January 27, 2009**, a Complaint Investigation and State Licensure. survey was conducted at Aspen Park Healthcare by the Bureau of Facility Standards/Department of Health & Welfare to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. **This survey found the most serious deficiency to be an isolated deficiency that constitutes actual harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies/Plan of Correction, CMS Form 2567, listing Medicare/Medicaid deficiencies, and a similar State Form 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. **Please provide ONLY ONE completion date for each Federal/State Tag in column X5 (Complete Date), to signify when you allege that each tag will be back in compliance. NOTE: The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct"**

(listed on page 2). After each deficiency has been answered and dated, the administrator should sign both the CMS Form 2567 and State Statement of Deficiencies, in the spaces provided, and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **February 23, 2009**. Failure to submit an acceptable PoC by **February 23, 2009**, may result in the imposition of civil monetary penalties by **March 16, 2009**.

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- Include dates when corrective action will be completed.

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

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS), if your facility has failed to achieve substantial compliance by **March 3, 2009 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **March 3, 2009**. A change in the seriousness of the deficiencies on **March 3, 2009**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **March 3, 2009** includes the following:

Denial of payment for new admissions effective **April 27, 2009**. [42 CFR §488.417(a)]

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

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **July 27, 2009**, if substantial compliance is not achieved by that time.

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

If you believe these deficiencies have been corrected, you may contact Loretta Todd, R.N. or Lorene Kayser, L.S.W., Q.M.R.P., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0036, Phone #: (208) 334-6626, Fax #: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **January 27, 2009** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

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

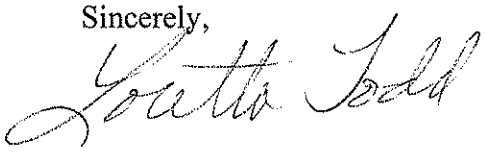
http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/2001_10.pdf
http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/2001_10_attach1.pdf
http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/2001_10_attach2.pdf

This request must be received by **February 23, 2009**. If your request for informal dispute

resolution is received after **February 23, 2009**, 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, please contact us at (208) 334-6626.

Sincerely,



LORETTA TODD, R.N.
Supervisor
Long Term Care

LT/dmj

Enclosures

IDAHO DEPARTMENT OF HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
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PHONE 208-334-6626
FAX 208-364-1888

February 24, 2009

Brian V. Sawyer, Administrator
Aspen Park Healthcare
420 Rowe Street
Moscow, ID 83843

Provider #: 135093

Dear Mr. Sawyer:

On January 27, 2009, a Complaint Investigation and State Licensure was conducted at Aspen Park Healthcare. Marcia Key, R.N., Rhonda Olsen, R.N. and Karen Marshall, R.D. conducted the complaint investigation. A total of 21 hours were required to complete this and an additional investigation.

The following documentation was reviewed:

- The identified resident's record;
- The facility's self-reported Significant Event Investigation Conclusion & Plan of Prevention report dated January 8, 2009; and
- The Resident Event Report Worksheet, dated January 1, 2009.

Four additional resident's records were also reviewed for falls in the facility.

The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00003942

ALLEGATION #1:

The complainant stated an identified resident usually had a mat on the floor next to the bed but this was not present in the new room. On January 1, 2009, the resident fell, resulting in a subdural hematoma. The resident was not a surgical candidate and died on January 4, 2009.

FINDINGS:

Based on the facility's self-reported investigation documentation and record review, it was determined the facility did not ensure a resident's safety was maintained. She was moved to another room and left unattended before all appropriate safety measures were in place. The specialty bed mattress was not in proper working condition, allowing the resident to fall out of bed and onto the floor, which was not padded with the proper floor mats. The resident suffered a head injury and died three days later.

The facility was cited at Federal Regulation F323 at the level of harm.

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

ALLEGATION #2:

The complainant stated the facility had moved an identified resident to another room without first contacting the responsible party.

FINDINGS:

A Significant Event Investigation Conclusions & Plan for Prevention report, dated January 8, 2009, documented that on January 1, 2009, at approximately 8:45 p.m.; the staff moved the identified resident to an adjacent room and assisted her into a different style bed after her roommate became ill with signs and symptoms of gastroenteritis. The resident fell out of bed at approximately 8:50 p.m. The report documented the physician and "family" was notified of the fall.

The Resident Event Report Worksheet, dated January 1, 2009, at 8:50 p.m., documented the Family/Power of Attorney was notified at 9:00 p.m.

The Resident Progress Notes, dated January 1, 2009, no time recorded, documented that the "family" was notified after the resident was observed lying on the floor.

There was no documented evidence, however, that the responsible party was notified prior to the room change to discuss the need for the move.

The Federal guidance at 42 CFR §483.15(e)(2) directs that a resident has a right to receive notice before the resident's room or roommate in the facility is changed.

The identified resident had a responsible party who was not contacted prior to the room change; as a result, the facility was cited at Federal Regulation 157.

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

Based on the findings of the complaint investigation, deficiencies were cited and included on the survey report. No response is necessary to this complaint report, as it will be addressed in the Plan of Correction.

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

Lorene Kayser

LORENE KAYSER, L.S.W., Q.M.R.P.
Supervisor
Long Term Care

LKK/dmj

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
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February 24, 2009

Brian V. Sawyer, Administrator
Aspen Park Healthcare
420 Rowe Street
Moscow, ID 83843

Provider #: 135093

Dear Mr. Sawyer:

On January 27, 2009, a Complaint Investigation and State Licensure was conducted at Aspen Park Healthcare. Marcia Key, R.N., Rhonda Olsen, R.N. and Karen Marshall, R.D. conducted the complaint investigation. A total of 21 hours were required to complete this and an additional investigation.

The identified resident's medical record was reviewed. The facility's Resident Event Report Worksheets were reviewed. Interviews were conducted with the administrator, the Director of Nursing, and licensed nurses who provided care to the identified resident while the resident was in the facility.

The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00003953

ALLEGATION #1:

The complainant stated that the identified resident had a gastrostomy tube in place at time of

admission to the facility. The complainant stated the resident reportedly disconnected the gastrostomy tube from her body by pulling the gastrostomy tube out. The complainant stated that the facility did not inform the complainant when the resident's gastrostomy tube was disconnected from the resident.

FINDINGS:

The identified resident was originally admitted to the facility on December 23, 2008, and discharged to a local hospital on December 28, 2008. The resident was discharged from the local hospital to a different hospital in another state. The resident was readmitted to the facility on January 2, 2009.

The identified resident's Physician's Orders for Enteral Nutrition form, dated December 23, 2008, ordered staff to provide the resident's nutrition by enteral tube feeding.

The identified resident's Medical Nutrition Therapy Assessment, dated December 24, 2008, and the resident's Nursing Assessment, dated December 25, 2008, both documented the resident received nutrition by enteral tube feeding.

The identified resident's Resident Progress Notes, dated December 27, 2008, at 11:30 p.m., documented the resident grabbed a nurse's arm, let go, and then grabbed the gastrostomy tube and pulled the tube from her body.

The facility's Resident Event Report Worksheet documented that on December 27, 2008, at 11:30 p.m., the identified resident pulled on the gastrostomy tube and the tube became displaced from the resident's body. The Resident Event Report Worksheet also documented that the resident's physician was notified on December 28, 2008, at 12:30 a.m.

However, the identified resident's Resident Event Report Worksheet documented that the family or power of attorney was not notified of the event until December 28, 2008, at 7:30 a.m., eight hours after the event occurred.

During an interview conducted with the administrator and the Director of Nursing, the facility stated the family or power of attorney was notified when the event happened. Although the facility stated the family or power of attorney was notified when the event happened, the documentation of the event indicated otherwise.

Based on record review and staff interview at the time of the investigation, it was substantiated that the facility did not immediately notify a family member or power of attorney when a resident

experienced a significant change and a need to significantly alter treatment. The facility was cited at F157 for noncompliance.

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

ALLEGATION #2:

The complainant stated that the facility was not administering the identified resident's gastrostomy tube feedings, four times a day, as ordered by the physician.

FINDINGS:

The identified resident's Skilled Nursing Orders, dated December 31, 2008, and signed by the resident's physician, ordered evaluations and treatments from Physical Therapy, Occupational Therapy and Speech Therapy.

The identified resident's Physician's Orders for Enteral Nutrition form, dated January 2, 2009, ordered staff to provide the resident with tube feedings four times per day.

According to the documentation in the identified resident's medical chart, after the January 2, 2009, readmission there was one day when the identified resident did not tolerate the tube feeding and the tube feeding was stopped due to discomfort experienced by the resident. The resident's tube feeding was held until nursing staff confirmed the resident's gastrointestinal tract could tolerate the tube feedings. On another day, the resident refused the tube feedings in the morning and Speech Therapy assisted the resident to eat later in the day. On another day, the resident received three tube feedings and ate one meal while monitored in the facility's therapy dining room.

The identified resident's Resident Progress Notes and Medication and Treatment Records documented that the facility monitored, provided and attempted to provide the resident's tube feeding four times a day after the January 2, 2009, readmission. In addition, the documentation in the resident's chart indicated therapies worked with the resident when she experienced difficulties with feedings.

Based on the record review at the time of the investigation, it could not be substantiated that the facility did not follow the physician's orders.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The complainant stated that the identified resident experienced a fifteen to twenty pound weight loss since admission to the facility on December 27, 2008.

FINDINGS:

The identified resident's Nursing Assessment, dated December 25, 2008, documented the resident's admission weight was 151.8 pounds.

On December 28, 2008, the identified resident was discharged from the facility to a local hospital due to the displacement of the resident's gastrostomy tube. The local hospital's Emergency Department Report documented the resident was admitted to the local hospital on December 28, 2008, and hydration for the resident was started.

On January 2, 2009, the identified resident was readmitted to the facility. The resident's readmission Nursing Assessment, dated January 2, 2009, documented that the resident weighed 146.5 pounds. The weight loss from 151.8 pounds on December 23, 2008, to 146.5 pounds on January 2, 2009, represented a weight loss of 5.3 pounds. Although the resident did lose weight, the resident was not in the facility from December 28, 2008, to January 2, 2009.

The identified resident's medical chart documented that the resident weighed 142.3 pounds on January 18, 2009. The weight loss from 146.5 pounds on January 2, 2009, to 142.3 pounds on January 18, 2009 represented a weight loss of 4.2 pounds in a sixteen days period.

Although it was verified that the resident did experience a 4.2 pound weight loss after readmission to the facility on January 2, 2009, the weight loss was not considered significant or severe. The 4.2 pound weight loss in a sixteen days period represented a weight loss of 2.8 percent. Federal regulations indicate a weight loss of five percent in one month is considered significant and a weight loss greater than five percent in one month is considered severe.

Based on record review at the time of the investigation, it could not be substantiated that the identified resident experienced a fifteen to twenty pound weight loss after admission to the facility.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

The complainant stated the identified resident was given gastrostomy tube flushes with normal saline. The complainant stated the licensed nurse was questioned about the procedure and the licensed nurse indicated the identified resident ' s physician ordered the gastrostomy flush with normal saline.

FINDINGS:

The identified resident's Physician's Orders For Enteral Nutrition form, dated January 2, 2009, directed staff to flush the feeding tube with one hundred and seventy milliliters of water every eight hours and with ten milliliters of water before and after medication administration.

The identified resident's Treatment Record and Resident Progress Notes documented that the nursing staff used water to flush the resident's gastrostomy tube.

The Director of Nursing and one of the registered nurses, who provided care to the identified resident, were asked if normal saline was kept in the resident's room, and what the saline would be used for. The registered nurse remembered using normal saline to clean out the syringe used to administer the resident's medications when the crushed medication became caught in the tip of the syringe. The nurse stated that the syringe was cleaned while he/she stood next to the sink in the resident's room and the saline solution went into the sink, not into the resident's body. The registered nurse also indicated that ordinary tap water was used to flush the resident's feeding tube as directed by the resident's physician's orders.

Based on record review and staff interviews at the time of the investigation, it could not be substantiated that a licensed nurse flushed the identified resident's "gastrostomy tube" with normal saline.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #5:

The complainant stated that the identified resident did not receive Coumadin as directed by the resident's physician.

FINDINGS:

The identified resident's medical record documented that during her stay in the facility, the resident received Coumadin in the correct dosage as ordered by the treating physician. She received no more than 7.5 milligrams (mg) per day. The physician ordered Coumadin 5 mgs and Coumadin 7.5 mgs to be administered on various alternating days, depending on the results of the resident's Prothrombin Time (PT) and International Normalized Ratio (INR).

The identified resident's medical record documented the PT/INRs were drawn on January 2, 5, 12, 16, and 19, 2009, as per the physician's orders.

Based on record review at the time of the investigation, it could not be substantiated that the identified resident did not receive Coumadin as directed by her physician.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #6:

The complainant stated the facility would not discharge the identified resident without a doctor's order and the resident's doctor reportedly would not order the discharge.

FINDINGS:

A review of the identified resident's medical record revealed the following documentation:

On January 9, 2009, the identified resident's physician wrote an order that the resident was not to leave the facility for overnight home visits and would reevaluate the order at a later date.

On January 19, 2009, a registered nurse wrote a letter to the identified resident's family member advising that discharge at that time was not advised.

The registered nurse, the Director of Nursing and the administrator were interviewed concerning the above documentation in the identified resident's medical record. All three staff members believed that without the supportive services of home health nursing, therapies, and additional nursing aide services, discharging the identified resident would be unsafe.

On January 19, 2009, the identified resident's physician wrote an order to discharge the resident to home.

Based on record review and staff interviews at the time of the investigation, it could not be substantiated that the facility would not permit the discharge of the resident.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

Based on the findings of the complaint investigation, deficiencies were cited and included on the survey report. No response is necessary to this complaint report, as it will be addressed in the Plan of Correction.

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

LORENE KAYSER, L.S.W., Q.M.R.P.
Supervisor
Long Term Care

LKK/dmj

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

PRINTED: 02/06/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135093	A. BUILDING B. WING	C 01/27/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN PARK HEALTHCARE	420 ROWE STREET MOSCOW, ID 83843

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following deficiencies were cited during a complaint investigation of your facility. The surveyors conducting the survey were: Marcia Key, BSN, WOCN, Team Coordinator Karen Marshall, MS, RD, LD Rhoda Olsen, RN, BSN Survey Definitions: MDS = Minimum Data Set assessment RAP = Resident Assessment Protocol RAI = Resident Assessment Instrument DON = Director of Nursing LN = Licensed Nurse CNA = Certified Nurse Aide ADL = Activities of Daily Living MAR = Medication Administration Record	F 000	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Aspen Park Healthcare does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Center admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Center reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.	
F 157 SS=D	483.10(b)(11) NOTIFICATION OF CHANGES A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).	F 157	**F157** **We are respectfully disputing this citation and are requesting Informal Dispute Resolution.** **Resident Specific** **Resident #'s 4 & 6 have discharged from the center.** **Other Residents** **Interdisciplinary Team (IDT) reviewed other residents for family notification of changes. No other concerns were identified.** **Facility Systems** **Licensed nursing (LN) staff is educated on timely notification of family for resident changes to include but not limited to, change in medical condition and room changes. LN re-education was provided for timely family notification.**	

RECEIVED
FEB 18 2009
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Brian V. Sauy ED — TITLE: Executive Director — (X6) DATE: 2/18/09

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135093	A. BUILDING B. WING	C 01/27/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN PARK HEALTHCARE	420 ROWE STREET MOSCOW, ID 83843

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F 157	Continued From page 1 The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on two complaints from the general public, record review, and staff interview, it was determined the facility did not ensure timely notification of interested family members for 2 of 2 sampled residents. Resident #4's gastrostomy tube (G-tube) became dislodged which constituted a significant change in condition. In addition, the facility did not contact a responsible party prior to a room change, which involved Resident #6. Findings include: 1. Resident #4 was admitted to the facility on 12/23/08 and readmitted on 1/2/09, with diagnoses which included dysphagia, reflux disease, and history of aspiration pneumonia. A Resident Event Report Worksheet, dated 12/29/08, documented the following: *Event Date: 12/27/no year, time: 23:30 (11:30 p.m.) *Notifications: - Physician, on 12/28/08 at 00:30 (12:30 a.m.) - Director of Nursing, on 12/28/08 at 7:00 a.m.	F 157	**Monitor** **The Director of Nursing Services (DNS) and/or designee will review residents to monitor that family notification occurs timely. Any concerns will be addressed immediately and discussed with the Performance Improvement (PI) committee as indicated. The PI committee may adjust frequency of the monitoring, as it deems appropriate.** **Date of Compliance** **March 3, 2009**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	135093		C 01/27/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 157	Continued From page 2 - Family/Power of Attorney, on 12/28/08 at 7:30 a.m. *Event Nature: Tube displacement, disconnection *Event Adverse Effect: Dislocation G-tube Based on the information documented on the Resident Event Report Worksheet, dated 12/29/08, the Family/Power of Attorney was notified 8 hours after the resident's G-tube became disconnected. On 1/27/09 at 3:07 p.m., the Administrator and the DON stated that the resident's family member was notified when the resident's G-tube became dislodged. The surveyors discussed with the facility that the documentation indicated otherwise. 2. Resident #6 was admitted to the facility on 2/19/04 with diagnoses which included dementia of Alzheimer's type, and history of paranoia and delusions. The guidance at §483.15(e)(2) indicates that a resident has a right to receive notice before the resident's room or roommate in the facility is changed. A Significant Event Investigation Conclusions & Plan for Prevention report, dated 1/8/09, documented that on 1/1/09 at approximately 8:45 p.m., the staff moved Resident #6 to an adjacent room and assisted her into a different style bed after her roommate became ill with signs and symptoms of gastroenteritis. The resident fell out of bed at approximately 8:50 p.m. The report documented the physician and "family" were notified of the fall.	F 157		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	135093		C 01/27/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 157	Continued From page 3 The Resident Event Report Worksheet, dated 1/1/09 at 8:50 p.m., documented the Family/Power of Attorney was notified at 1/1/09 at 9:00 p.m. The Resident Progress Notes, dated 1/1/09, no time recorded, documented that the "family" was notified after the resident was observed lying on the floor. There was no documented evidence the responsible party was notified prior to the room change to discuss the need for the move.	F 157		
F 323 SS=G	483.25(h) ACCIDENTS AND SUPERVISION The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on a complaint from the general public, the facility's self-reported investigation documentation, and record review, it was determined the facility did not ensure a resident's safety was maintained. She was moved to another room and left unattended before all appropriate safety measures were in place. The specialty bed mattress was not in proper working condition, allowing the resident to fall out of bed and onto the floor which was not padded with the proper floor mats. The resident suffered a head injury and died 3 days later. This involved 1 of 5	F 323	F323 **Resident Specific** **Resident # 6 has been discharged from the center as noted in the 2567.** **Other Residents** **The IDT made rounds to identify other potential needs for resident safety devices. No additional items were identified.** **Facility Systems** **Nursing staff is educated on proper airbed function and the proper sequencing of transferring residents with their safety devices.** **Monitor** **The Director of Nursing Services (DNS) and/or designee will review residents transferred to different rooms for proper sequencing of safety devices. The Executive Director (ED) and/or designee will monitor airbeds for proper functioning prior to and periodically during use. Any concerns will be addressed immediately and discussed with the Performance Improvement (PI)**	

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	135093		C 01/27/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN PARK HEALTHCARE	420 ROWE STREET MOSCOW, ID 83843

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F 323	Continued From page 4 sampled residents reviewed for falls (#6). Findings include: Resident #6 was admitted to the facility on 2/19/04 with diagnoses which included dementia of Alzheimer's type, and history of paranoia and delusions. The resident's most recent quarterly MDS, dated 11/30/08, identified the resident was moderately impaired in her cognitive skills for daily decision-making. She was usually understood and usually able to understand others. She was dependent in many of her care needs and required assistance in bed mobility and transfers. She had a pressure reducing mattress on her bed. The resident's care plan, dated 11/28/08, identified she was at risk for falls due to an unsteady gait, impaired judgement, decreased mobility and decreased strength. The care plan directed staff to ensure the resident's bed was maintained in a low position and a floor mat was placed next to the bedside. On 1/8/09 the Bureau of Facility Standards received a fax from the facility, titled, Significant Event Investigation Conclusions & Plan for Prevention. The report documented that Resident #6 was moved to another room on 1/1/09 at approximately 8:45 pm, after her roommate started exhibiting signs and symptoms of gastroenteritis. Due to the late hour, the staff decided not to move Resident #6's bed, but rather assisted her into a similar bed in an adjacent room. She was positioned on her back in the middle of the airbed which was in the lowest position. The staff then left the room to obtain her	F 323	**committee as indicated. The PI committee may adjust frequency of the monitoring, as it deems appropriate.** **Date of Compliance** **March 3, 2009**	

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F 323	Continued From page 5 floor mats and other belongings. At approximately 8:50 pm, the staff heard the resident calling out. When staff returned to the room the resident was observed laying on her left side, next to her bed, on the floor. There was swelling to her left orbital area and she complained of leg and back pain. The LN assessed the resident then brought her to the nurse's station in a wheelchair for observation. The physician, the emergency room, and family were notified. The resident was continually observed until she was transported by non-emergent ambulance to the hospital at 9:15 pm. The diagnosis was an "acute intraparenchymal hemorrhage to the right frontal lobe and left post central gyrus." The investigation report also documented, "The original airbed for [Resident #6] was owned by the nursing center and had served her without issue. The airbed that [Resident #6] was transferred to was a rented bed. Investigation shows that it had a small air leak, which caused it to be slightly underinflated. With a shift in body weight, the resident rolled off the edge of the bed and the bolster was not high enough to stop her motion. It does not appear that [Resident #6] attempted to get up, nor had she attempted to in greater than a year. She simply rolled off the edge of the bed to the floor approximately 15 inches below. As staff was retrieving [Resident #6's] belongings, there were no floor mats in place. Plan to prevent Recurrence: *All airbeds were checked by maintenance for integrity. No other malfunctions or air leaks were identified. *Staff was re-educated on proper airbed function and the proper sequencing of transferring residents with their safety devices."	F 323		

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F 323	Continued From page 6 The Resident Progress Notes and the Resident Event Report Worksheet, both dated 1/1/09, also documented the incident as addressed in the Significant Event Investigation Conclusions & Plan for Prevention report. The hospital record, dated 1/1/09 at 11:10 pm, documented Resident #6 was discharged back to the facility on comfort measures. The Resident Progress Notes, dated 1/1/09 at 11:45 pm, through 1/4/09 at 5:15 pm, documented the resident received comfort care and pain management until her death on 1/4/09 at 5:10 pm. The facility failed to ensure Resident #6's safety to the extent possible when staff did not perform an inspection of the rented airbed prior to assisting the resident onto the bed, and when staff did not ensure her other safety equipment, the floor mats, were in the room and ready to be placed on the floor immediately after assisting the resident to bed.	F 323		

Bureau of Facility Standards

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C 000	16.03.02 INITIAL COMMENTS The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2. The following deficiencies were cited during a complaint investigation of your facility. The surveyors conducting the survey were: Marcia Key, BSN, WOCN, Team Coordinator Karen Marshall, MS, RD, LD Rhoda Olsen, RN, BSN Survey Definitions: MDS = Minimum Data Set assessment RAP = Resident Assessment Protocol RAI = Resident Assessment Instrument DON = Director of Nursing LN = Licensed Nurse CNA = Certified Nurse Aide ADL = Activities of Daily Living MAR = Medication Administration Record	C 000	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Aspen Healthcare Center does not admit that the deficiencies listed on the State Form exist, nor does the center admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The center reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency. RECEIVED FEB 18 2009 FACILITY STANDARDS	
C 155	02.100,08 NOTIFICATION OF CHGE PTNT/RSDNT STATUS 08. Notification of Change in Patient/Resident Status. There shall be written policies and procedures relating to notification of next of kin, or sponsor, in the event of a significant change in a patient's/resident's status. This Rule is not met as evidenced by: Please refer to F 157 as it addresses the facility's failure to ensure timely family notification after a resident's significant change in condition.	C 155	Refer to the Plan of Correction at F157. Refer to the Plan of Correction at F323.	

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Brian V. Sauer TITLE Exec Director (X6) DATE 2/18/09

Bureau of Facility Standards

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C 790	Continued From page 1	C 790		
C 790	02.200,03,b,vi vi. Protection from accident or injury; This Rule is not met as evidenced by: Please refer to F 323 as it addresses the facility's failure to protect a resident from a fall injury.	C 790		