



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 Eder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
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FILE COPY

February 18, 2015

James R. Burt, Administrator
Grangeville Health & Rehabilitation Center
410 East North Second Street
Grangeville, ID 83530-2258

Provider #: 135080

Dear Mr. Burt:

On **January 30, 2015**, a Recertification and State Licensure survey was conducted at Grangeville Health & Rehabilitation Center by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be one that comprises a pattern that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567 listing Medicare and/or Medicaid deficiencies 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. **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). **Please provide ONLY ONE completion date for each federal and state tag 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 both the Form CMS-2567 and State Form, Statement of Deficiencies and Plan of Correction in the spaces provided and

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return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **March 3, 2015**. Failure to submit an acceptable PoC by **March 3, 2015**, may result in the imposition of civil monetary penalties by **March 23, 2015**.

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 both the federal survey report, Form CMS-2567 and the state licensure survey report, State Form.

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 6, 2015 (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 6, 2015**. A change in the seriousness of the deficiencies on **March 6, 2015**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **March 6, 2015** includes the following:

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Denial of payment for new admissions effective **April 30, 2015**. [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 30, 2015**, if substantial compliance is not achieved by that time.

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

If you believe these deficiencies have been corrected, you may contact Lorene Kayser, L.S.W., Q.I.D.P., 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, 83720-0009; phone number: (208) 334-6626, Option #2; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **January 30, 2015** 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 noncompliance at the time of the revisit, if appropriate.

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

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

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

- BFS Letters (06/30/11)

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2001-10 Long Term Care Informal Dispute Resolution Process
2001-10 IDR Request Form

This request must be received by **March 3, 2015**. If your request for informal dispute resolution is received after **March 3, 2015**, 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 Lorene Kayser, L.S.W., Q.I.D.P., 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 cursive script that reads "Nina Sanderson".

NINA SANDERSON, L.S.W., Supervisor
Long Term Care

NS/dmj
Enclosures

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

PRINTED: 02/18/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135080	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/30/2015
NAME OF PROVIDER OR SUPPLIER GRANGEVILLE HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 410 EAST NORTH SECOND STREET GRANGEVILLE, ID 83530	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following deficiencies were cited during the annual federal recertification survey of your facility. The surveyors conducting the survey were: Rebecca Thomas, RN, Team Coordinator, and Sherri Case, LSW, QIDP The survey team entered the facility on January 26, 2015, and exited on January 30, 2015. Survey Definitions: ADL = Activities of Daily Living BIMS = Brief Interview for Mental Status cm = Centimeters CNA = Certified Nurse Aide DON = Director of Nursing LN = Licensed Nurse MAR = Medication Administration Record MDS = Minimum Data Set assessment mg = Milligrams PRN = As Needed TID = Three times per day QID = Four times per day	F 000	"This plan of Correction is submitted as required under Federal and State regulations and statutes applicable to skilled nursing facilities. This plan of correction does not constitute an admission of liability, and such liability is hereby specifically denied. The submission of this plan does not constitute agreement by the facility that the surveyor's conclusions are accurate, that the findings constitute a deficiency, or that the scope or severity regarding any of the deficiencies cited are correctly applied."	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to maintain a	F 241	Please accept this plan of correction as our credible allegation of compliance F-241 Resident Specific: Resident #7 will have her catheter bag covered at all times	

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

TITLE

(X9) DATE

Administrator

4/9/15

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 241	Continued From page 1 resident's dignity when the resident was observed to have an exposed foley catheter bag. This was true for 1 of 3 (#7) residents sampled for catheter care. This failed practice created the potential for a negative effect on the resident's self-esteem. Findings included: Resident #7 was admitted to the facility on 7/12/13 with diagnoses which included multiple sclerosis, pneumonia and congestive heart failure. The resident's 1/1/15 recapitulation Physician Order Report included an order for a Foley Catheter related to the diagnosis of end stage multiple sclerosis. On 1/28/15 at 9:30 a.m. the resident was observed on her bed with the foley catheter bag attached to the visible side of the bed frame. The catheter bag was observed to be more than 1/2 full of urine. On 1/28/15 at 9:35 a.m. LN #2 was shown the exposed catheter bag and stated the catheter bag should have been in a modesty cover. On 1/29/15 at 6:30 p.m. the Administrator and the DON were informed of the above concern. The facility provider no further information.	F 241	Other Residents: Please see systemic changes all residents with foley catheters will have their catheter bags covered at all times. Systemic Failure: A new C.N.A. failed to implement dignity measures. This C.N.A. was personally in serviced. Systemic Changes: All nursing staff have been verbally in serviced on importance of maintaining resident's dignity in all aspects of their care and daily living and to provide an environment that maintains dignity and respect and to promote individuality. Including and not limited to keeping catheter bags covered at all times, resident privacy, clothing protectors etc... We will continue to in service at each monthly staff meeting to ensure all staff understanding.		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be	F 246			

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F 246	Continued From page 2 endangered. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility did not ensure call lights were accessible for a random resident (#15). Inability to access the call light placed the resident at risk to have unmet needs and a negative effect on his psychosocial well-being. Findings included: Resident #15 was admitted to the facility on 11/26/13 with diagnoses which included impairment both eyes and osteoporosis. On 1/26/15 at about 1:30 p.m. Random Resident #15 was observed on his bed talking to visitors. The resident's call light was observed to be at the top of the bed, under the mattress. The resident was asked if he could reach his call light and attempted to find the light. One of the visitors stated the resident was blind and would not be able to find the call light. Nursing Assistant #3 was asked about the call light and stated the call light should have been clipped to the resident's pillow where the resident could reach it. The CNA then clipped the call light to the pillow. On 1/29/15 at 6:30 p.m. the Administrator and the DON were informed of the above concern. The facility provider no further information.	F 246	Monitors: DON or designee will monitor all residents for all areas of dignity (privacy, clothing protectors, foley bags etc...) weekly times four and monthly times five. Will in service all staff at staff meetings monthly to ensure staff understanding of residents dignity and respect in full recognition of his/her individuality, all new C.N.A.s will be trained one on one on hire regarding all areas of resident dignity (resident privacy, clothing protectors, foley bags etc...), using F241 checklist. DON or designee will report finding at the QA meeting and will make changes to the above plan of correction as needed. Date of Compliance 03/03/2015		
F 252 SS=E	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE	F 252			

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F.252	Continued From page 3 ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, it was determined the facility failed to ensure a comfortable environment was provided for residents. This was true for rooms 103, 105, 302, 303 and 308. The deficient practice had the potential for psychosocial harm if residents became embarrassed or depressed from an unappealing environment. Findings included: During the initial tour room 103 was observed to have under - the counter drawers by the sink, which were faded and missing varnish. Additional under - the counter drawers identified with missing varnish were observed in rooms 105, 303 and 308. The bedside dressers in room 302 were also observed to be scratched and gouged. On 1/28/15 during at 3:00 p.m. the Administrator and Maintenance Assistant were shown drawers which needed refinished. The Maintenance Assistant stated the facility had been waiting until warmer weather to refinish the drawers.	F 252	F-246 Resident Specific: Resident # 15 will have call light in reach at all times. Other Residents: All residents will have call light placed in an easily accessible area and clipped to secure spot to ensure ability to use and meet resident needs. Systemic Changes: Staff have been verbally in serviced on maintaining residents safety and well being by placing call light in secure area with a clip to ensure resident access.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to	F 280	Monitors: DON or designee will observe ten residents weekly times four and	

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F 280	<p>Continued From page 4</p> <p>participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure care plans were updated for 2 of 7 (#s 3-4) residents reviewed for care plans. Failure to ensure care plans were revised to include interventions for prevention of falls and pressure ulcers created the potential for residents to not get needed care/services. Findings included: 1. Resident #3 was admitted to the facility on 9/10/14 with multiple diagnoses which included rehabilitation, COPD (chronic obstructive pulmonary disease) and muscle weakness.</p> <p>The Pressure Ulcer Care Plan, dated 9/10/14, documented the following approaches with a start date of 12/12/14: "Heelbos on at all times WIB [when in bed]. May wear during day if he chooses; and,</p>	F 280	<p>monthly times five to ensure call light placement to meet residents needs. DON or designee will report findings at the QA meeting and will make changes to the above plan of correction as needed.</p> <p>Date of Compliance 03/03/2015</p> <p>F-252</p> <p>Resident Specific: Drawers in rooms 103,105,302, 303, and 308 have been repaired</p> <p>Other Residents: Staff educated to report any furniture - drawers & doors that may be missing varnish, scratched or gouged.</p>		

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F 280	<p>Continued From page 5 *12/12/14 - Heelz [sic] up WIB."</p> <p>Resident #3 was observed to be laying in bed on 1/27/15 at 9:35 AM, 1:40 PM, 2:40 PM and 3:00 PM, and did not have his heelbos on his feet or his heels elevated.</p> <p>On 1/27/15 at 3:20 PM, CNA #5 stated the resident frequently refuses to wear the Heelbos and have his heels elevated. When asked what she did when the resident refused, she stated she left them off.</p> <p>On 1/28/15 at 3:45 PM, with the DON in attendance, LN #4 stated the resident frequently refused depending on his mood. When asked what care plan approaches were documented in the care plan for when the resident refused to wear the Heelbos or have his heels elevated, the DON shook her head, "No." LN #4 stated, "I see what you mean, like re-approach, education, things like that."</p> <p>2. Resident #4 was admittted to the facility on 5/4/10 and readmitted on 2/23/11 with multiple diagnoses which included dementia, dysrhythmia, hypertension and macular degeneration.</p> <p>The Fall Care Plan Update, dated 12/27/14, documented an approach for frequent checks but did not document a frequency.</p> <p>On 1/29/15 at 3:55 PM, the DON stated frequent checks meant staff would check on the resident every 30 minutes and staff document on the sheet inside the resident's closet. When asked if the frequency should be included in the care plan, the DON stated, "It's not on the care plan and it should be."</p>	F 280	<p>Monitors:</p> <p>Administrator will observe all drawers in all resident rooms weekly times four and monthly times five and will report findings at the QA meeting and will make changes to the above plan of correction as needed.</p> <p>Date of Compliance 03/03/2015</p> <p>F-280</p> <p>Residents Specific:</p> <p>Residents #3 and #4 had their care plans revised to include interventions for prevention of falls and pressure ulcers and their care plans have been updated and individualized to meet their specific needs.</p>	

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F 309	<p>Continued From page 7</p> <p>(grams) of carbohydrate in the form of glucose gel, any fruit juice or regular soft drink and to recheck the BG in 15 minutes.</p> <p>1. Resident #3 was admitted to the facility on 9/10/14 with multiple diagnoses which included rehabilitation, diabetes mellitus type II, COPD (chronic obstructive pulmonary disease).</p> <p>The Physician Order Report (recapitulation orders) for January 2015 documented an order for FSBS AC & HS, (fasting blood sugar checks before meals and at bedtime), with a start date of 11/28/14. The order did not contain direction on what staff would do for high or low BG levels. On 9/10/14, there were orders for two oral diabetic medications, Amaryl 2 mg, oral, twice per day, and Metformin 1000 mg, oral, twice per day.</p> <p>Review of the resident's January 2015 Medication Flowsheet for FSBS, from 1/1 through 1/26/15, documented BG's were above 200 at least 33 times. There was documentation BG levels were above 300 at least 14 times. However, there was no documentation the resident's physician was notified.</p> <p>On 1/28/15 at 1:20 PM, the DON was asked for the facility's policy and procedure for hyperglycemia. The DON stated, "I do not have one for hyperglycemia, those residents are usually on a sliding scale."</p> <p>On 1/28/15 at 3:45 PM, the DON and LN #4 was asked about the lack of direction in the physician's order for a resident who was not on a sliding scale. LN #4 stated the order usually documented to call the physician. When asked</p>	F 309	<p>skin integrity, falls, and or any triggered area in the MDS will be reviewed every morning in stand up meeting and care plans will be adjusted as necessary.</p> <p>Comprehensive care plans will be reviewed at weekly care plan meeting to assure all appropriate interventions are in place reviewed and or updated as needed by IDT team.</p> <p>Monitors:</p> <p>DON or designee will review care plans weekly times four and monthly times five to ensure care plans include appropriate interventions to meet resident specific needs for falls and pressure ulcers and all other specified care plan needs, and to include what staff are to do if residents refuse interventions.</p> <p>Date of Compliance</p> <p>03/03/2015</p>		

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F 309	<p>Continued From page 8</p> <p>about the lack of direction in the order for a resident who was not on an insulin sliding scale, the DON stated, "Right." When asked what should have been done, the DON stated, "Well, if symptomatic, they should at least update the doctor. The resident's physician was here and reviewed his chart on Friday [1/16/15] and would have looked at his blood sugars." When asked what the facility considered a high BG level and what was done, the DON stated, "The physician would have to direct us and I don't have any documentation in the nurses notes where the physician was notified of the high blood sugars. I would consider a high blood sugar anything above 400, because that is when we would call the physician for those who had sliding scales."</p> <p>2. Resident #10 was admitted to the facility on 12/6/11 with multiple diagnoses which included adult failure to thrive and diabetes mellitus, type II.</p> <p>The Physician Order Report for January 2015, documented an order for FSBS AC & HS with a start date of 12/6/11.</p> <p>Review of the resident's December 2014 Medication Flowsheet, under Novolog Insulin Sliding Scale, documented the following BG levels were below 70. The following BGs did not include documented interventions or that BGs were rechecked within 15 minutes as per the facility's protocol: *12/2 - BG at 7:00 AM = 62; *12/5 - BG at 4:00 PM = 63; *12/14 - BG at 4:00 PM = 54; and, *12/24 - BG at 7:00 AM = 64.</p> <p>On 1/28/15 at 1:20 PM, the DON provided a copy</p>	F 309	<p>F-309</p> <p>Residents Specific:</p> <p>Residents #3 and #10 have had their blood sugars and our protocol reviewed by their primary care providers to ensure appropriate interventions are in place and documentation provided.</p> <p>Other Residents:</p> <p>See systemic changes</p> <p>All residents & orders for FSBS have been reviewed to ensure LN are following protocol & providing documentation of action & physician notification.</p> <p>Systemic Changes:</p> <p>All licensed nurses have been individually in serviced on policy and procedure regarding hyper/hypoglycemia protocol and</p>		

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OMB NO. 0938-0391

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F 309	Continued From page 9 of the facility's new Hypoglycemia Treatment Protocol, which included protocols for BGs below 80. She stated the policy went into effect 1/23/15. She then provided a copy of the previous Hypoglycemia Treatment Protocol, which included protocols for BGs less than 70, and stated the old policy was in effect from 8/11/11 until 1/22/15. On 1/29/15 at 4:50 PM, the DON stated she did not see documentation of interventions or that BGs were rechecked within 15 minutes. When asked what should have been done, the DON stated, "The nurses should have followed the protocol." On 1/29/15 at 6:45 PM, the Administrator and DON were made aware of the quality of care concerns related to blood sugars. No further information was provided by the facility.	F 309	importance of appropriate documentation and physician notification. Monitors: DON and designee will review all residents with orders for finger stick blood sugars weekly times four and monthly times five to ensure hyper/hypoglycemia protocol is being followed and that there is appropriate documentation including physician notification. DON or designee will report findings at the QA meeting and will make changes to the above plan of correction as needed.	
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition	F 329	Date of Compliance 03/03/2015	

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F 329	<p>Continued From page 10</p> <p>as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, it was determined the facility failed to ensure behaviors were adequately monitored for the use of medications used for the treatment of dementia, depression and anxiety. This was true for 3 of 7 (#s 1, 6 and 7) sampled residents reviewed for unnecessary medications. This failed practice placed residents at risk for unanticipated declines or newly emerging or worsening symptoms. Findings included:</p> <p>1. Resident #1 was admitted to the facility on 3/3/14 with diagnoses which included dementia and hypertension.</p> <p>The Physician Order Report, dated 1/1/15, documented, Aricept 10 mg at bedtime for dementia with a start date of 10/7/14.</p> <p>Resident #1's 3/20/14 Care Plan for Cognitive Loss/Dementia had an Approach with a start date of 6/11/14, which documented the resident "...has struggled with eating packets of sugar and drinking the liquid creamers...Staff will redirect as needed....."</p>	F 329	<p>F-329</p> <p>Resident #1 has had her care plan updated to be specific on how staff are to "re-direct" resident when/if she hoards sugar packets and creamers. Care plan also updated to describe the "hoarding behavior." Behavior monitors updated to identify these behaviors.</p> <p>Resident #6 has had her care plan updated to include residents specific belief system, and to define "clear boundaries" and "expectations". Also includes when to implement 1 on 1, and when specifically to remove the resident from activities and what is an unacceptable behavior. Care plan lists specific socially inappropriate behaviors and what behaviors would endanger others and when staff are to intervene and what they are to do specifically if resident refuses cares.</p>		

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F 329	<p>Continued From page 11</p> <p>The dietician provided documentation the resident had weight gain identified on 5/30/14 and the care plan had been updated on 6/11/14 to address behaviors of hoarding of sugar packets and creamers.</p> <p>On the afternoon of 1/29/14, the Dietary Manager stated the resident had not had any health problems due to the increased weight. The resident was observed to "load her pockets" with sugar packets and cookies. The facility had not placed nutritional restrictions on Resident #1 but had encouraged the resident to limit sugar and snacks.</p> <p>On 1/29/15 at 4:00 p.m., the LSW was asked about the 6/11/14 care plan and stated the Care Plan did not describe the hoarding behavior was exhibited or include resident specific interventions as how to "redirect" the resident. The LSW stated the facility had not monitored the behavior of hoarding. Without criteria identified in the Care Plan or documentation the behavior was monitored the facility would not be able to determine the severity of the behavior.</p> <p>2. Resident #6 was admitted to the facility on 2/20/14 with diagnoses which included schizoaffective disorder, anxiety, dementia and pain.</p> <p>The Resident's 1/1/15 (recapitulation) Physician Order Report included orders for Lexapro (antidepressant) 20 mg every day for depression (start date 2/20/14) and Abilify (antipsychotic) 15 mg every day for schizoaffective disorder (start date 7/22/14).</p> <p>The resident's 3/10/14 Behavioral Symptoms</p>	F 329	<p>Resident #7 care plan has been updated to identify specific "noted" behaviors for resisting cares physically and verbally aggressive behaviors and socially inappropriate and disruptive behaviors.</p> <p>Other Residents:</p> <p>All residents care plans will be updated to be specific in identifying "noted" behaviors. They will be specific for staff intervention for each noted behavior. Each resident will be reviewed to ensure drugs are not ordered; in excessive doses (including duplicate therapy), for excessive duration, without adequate monitoring, without indications for use, or in the presence of adverse consequences which indicate the dose should be reduced or discontinued.</p>	

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F 329	<p>Continued From page 12</p> <p>documented a goal for the resident not to harm self or others during delusional periods.</p> <p>The Approach section for the behavioral care plan documented the resident had delusions regarding pregnancy. Staff were instructed to not deny the resident's belief system and establish clear boundaries and expectations for the resident. The Care Plan did not include what the resident's belief system was or what the clear boundaries and expectations for the resident were. Other approaches for the resident were to provide 1 to 1 with the resident as needed, remove the resident from group activities when the resident's behavior was unacceptable and to provide care and a schedule which resembles the resident's prior lifestyle. There was no further information when to implement the 1 to 1, when to remove the resident from activities or what behavior was "unacceptable." Additionally the care plan included an approach to see the "other behavior care plan."</p> <p>The other care plan referred to for Behavioral Symptoms, had a start date of 3/10/14, and identified the antipsychotic medication. The behavioral section documented in the past the resident had been a threat to herself and/or others. The goal section documented the resident's socially inappropriate behaviors had decreased significantly and examples of behavior were "none."</p> <p>The Approach section included the physician documented past reductions in medication had failed and the medication should continue. Other approaches were to not seat other residents close to the resident, to allow the resident to have control over the situation if possible, assess if the</p>	F 329	<p>Systemic Failure:</p> <p>Failed to update care plan in a timely manner to reflect newly developed behaviors and interventions. Failed to discontinue "hoarding" care plan when resident no longer exhibited behaviors.</p> <p>Systemic Changes:</p> <p>MDS Coordinator will ensure all care plans are specific to meet each residents individual needs regarding behaviors and staff intervention. Behaviors will be identified and care planned with staff intervention and updated in a timely manner. Side-effects monitors and behavior monitors are specific for each medication and behavior. Side-effects monitors and behavior monitors have been added to the nursing MAR. Pharmacy will monitor monthly for unnecessary drugs, duplicate therapy, black box</p>		

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F 329	<p>Continued From page 13</p> <p>behavior endangered the resident or others, intervene if necessary and a behavior monitor was in place. The Care Plan did not include what the behaviors that would endanger others were, when to not seat other residents close to the resident or when to intervene. The Care Plan did not include any information regarding the resident refusing cares.</p> <p>The resident's medical record included Behavior Monitor sheets for 1/15 identified the antipsychotic medication and behaviors of refusing cares and physical/verbal aggression. The Behavior Monitor sheets did not document how the behaviors of refusing cares was exhibited (refusing bathing, toileting etc.) or how verbal/physical aggression (swearing/hitting etc.) was exhibited. There were no behaviors of refusing care or aggression documented.</p> <p>On 1/29/15 at approximately 4:00 p.m., the LSW was asked how staff knew what the resident's belief system was. The LSW stated the staff were informed at an in-service. It was unclear how staff not in attendance of the in-service would be informed of the resident's belief system. When asked what the clear boundaries for the resident were the LSW stated the approach needed to be eliminated. When asked how staff knew when to implement the 1 to 1 or what activities that resembled "the resident's prior lifestyle" and the other approaches the LSW stated the care plan needed to be more specific.</p> <p>3. Resident #7 was admitted to the facility on 7/12/13 with diagnoses which included multiple sclerosis, dementia, pneumonia and congestive heart failure.</p>	F 329	<p>warnings and appropriate dosage for all residents including those with a diagnosis of dementia, also to monitor the need for dose reductions and appropriate diagnosis. Staff training provided on how and what to report and who to report it to.</p> <p>Monitors:</p> <p>DON or designee will review five care plans weekly times four and monthly times five to make sure each care plan lists specific behaviors and staff interventions to meet each residents specific needs for each listed behavior and specific staff interventions are listed to ensure behavior monitors reflect any PRN medication given for any specific behavior, and documentation to reflect behaviors and interventions. Will review behavior monitors for newly developed behaviors or side effects to medications and follow up with MDS Coordinator and</p>	

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F 329	<p>Continued From page 14</p> <p>The resident's 1/1/15 recapitulation Physician Order Report included an order for Ativan (anxiolytic) 0.5 mg as needed for anxiety with a start date of 10/18/13.</p> <p>The resident's 4/18/14 Behavioral Symptom care Plan documented a goal to not harm self or others. The behaviors identified were refusing cares, removing catheter and attempting to throw self out of bed. The Care Plan identified the medication as Ativan.</p> <p>The Approach section included to allow the resident to have control over situations, administer medications, observe an report socially inappropriate/disruptive behaviors and the behaviors had not been exhibited for "quite some time." The care plan did not identify behaviors of resisting cares, being physically or verbally aggressive.</p> <p>A January 2015 Behavior Monitor sheet identified no behaviors of refusing cares or agitation. The January 2015 Behavior Monitor sheet for behaviors of physical/verbal aggression and being manipulative of staff documented a behavior on the 1/25/15 night shift (10:00 p.m. to 6:00 a.m.) The Behavior Monitor documented the intervention of redirection was effective for the behavior.</p> <p>The resident's 1/15 as needed medication sheet documented on 1/25/15 the resident received 0.5 mg of Ativan at 7:45 p.m.(evening shift). The back of the medication sheet documented the resident was less anxious at 8:20 p.m.</p> <p>Note: The behavior of aggression was documented on the night shift on 1/25/15 and the</p>	F 329	<p>Social Services for care plan revision and physician notification. Will review with pharmacist every month to ensure each residents drug regiment is free from unnecessary drugs, duplicate therapies, black box warnings reviewed, and appropriate dosing in place. DON or designee will report findings at QA meeting and will make changes to the above plan of correction as needed.</p> <p>Date of Compliance</p> <p>03/03/2015</p> <p>F-332</p> <p>Resident Specific:</p> <p>Residents #6, #13 and #14 Primary Care Physicians and responsible parties have been updated regarding medications being given after meals. No adverse side effects were noted. Omeprazole will be given 1/2 hour</p>	

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F 329	Continued From page 16 only intervention was redirection, however the medication was documented as given on 1/25/15 on the evening shift when no behaviors were documented. The resident's 1/25/15 nursing notes document at 5:27 p.m. the resident was having vision difficulty due to getting perfume in her eye during care. On 1/29/15 at 9:00 a.m. the LSW stated the medication was started due to behaviors of the resident pulling out her catheter, trying to get out of bed and crying. The LSW stated when the resident refused cares staff would leave, wait 15 minutes and reapproach but it was not in the care plan. On 1/30/15 at 10:00 a.m., the Administrator and the DON were informed of the resident receiving an as needed medication for behaviors when the behavior monitor documented no behaviors. The facility provided no further information.	F 329	prior to meals and other medications per physician's orders. Other Residents: See systemic changes. All other residents will be given Omeprazole as directed by their Primary Care Physician. All other medications will be dispensed per physicians orders. Systemic Failure: Too many medications were due on or near the same time making it difficult to get all medications dispensed in an appropriate time frame.	
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure it maintained a medication error rate less than 5 percent. This was true for 3 of 27 medications (11 percent) during medication pass	F 332	Systemic Changes: All licensed staff have been verbally in serviced on the six rights of medication pass. Medication administration times have been changed to allow	

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F 332	<p>Continued From page 16</p> <p>observation which affected 3 of 6 residents (#s 6, 13, and 14). This failure created the potential for the affected residents to receive less than optimum benefit from prescribed medication. Findings included:</p> <p>1. Resident #6's Physician Order Report (recapitulation orders) for January 2015, included an order for Omeprazole delayed release, 20 mg, daily, "take on an empty stomach 30 minutes before meals."</p> <p>On 1/29/15 at 8:30 AM, LN #1 was observed to administer Omeprazole to Resident #6 after the resident had eaten breakfast. The medication label documented, "Take one capsule by mouth every day in the morning on empty stomach 30 min before breakfast."</p> <p>2. Resident #13's Physician Order Report for January 2015, included an order for Omeprazole delayed release, 20 mg, daily, "take on an empty stomach 30 minutes before breakfast."</p> <p>On 1/29/15 at 8:40 AM, LN #1 was observed to administer Omeprazole to Resident #13 after the resident had eaten breakfast. The medication label documented, "Take one capsule by mouth every day in the morning on empty stomach 30 min before breakfast."</p> <p>3. Resident #14's Physician Order Report for January 2015, included an order for Omeprazole delayed release, 40 mg, daily, "take on an empty stomach 30 minutes before breakfast."</p> <p>On 1/29/15 at 8:50 AM, LN #1 was observed to administer Omeprazole to Resident #14 after the resident had eaten breakfast. The medication</p>	F 332	<p>optimal time for medication administration allowing licensed nurses to give specific assigned medications in the appropriate time frame.</p> <p>Monitors:</p> <p>DON or designee will observe medication pass weekly times four and monthly times five to ensure all medications are being dispensed per physicians orders and that licensed nurses are following the six rights of medication pass. Will review all MARs to ensure that the newly implemented time frames are effective and implemented correctly. DON or designee will report findings at QA meeting and will make changes to the above plan of correction as needed.</p> <p>Date of Compliance</p> <p>03/03/2015</p>	

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F 332	Continued From page 17 label documented, "Take one capsule by mouth every day in the morning on empty stomach 30 min before breakfast." The Nursing 2014 Drug Handbook, page 1026, states: Omeprazole - Oral Administration: "Give drug at least 1 hour before meals." On 1/29/15 at 9:20 AM, LN #1 was asked about giving Omeprazole after breakfast to Resident #s 6, 13 and 14. She stated, "I do understand Omeprazole should be given on an empty stomach."	F 332	F-441 Resident Specific: Resident #7 has her foley catheter bag in an appropriate cover and has been placed in an appropriate manner as to not touch her fall mat. Other Residents: All other residents with foley catheters will have their catheter bag placed in an appropriate cover and have been placed in a manner as to not touch the fall mat or the floor. Systemic Changes: All staff have been verbally in serviced on infection control protocol regarding placement of foley catheter bag, to prevent spread of infection or potential spread of infection.		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program	F 441			

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F 441	<p>Continued From page 18</p> <p>determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) 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.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview it was determined the facility failed to ensure a urinary drainage bag did not touch a floor mat beside the resident's bed. This was true for 1 of 3 residents sampled for catheter care (#7) and increased the potential for the resident to develop infections from cross-contamination. Findings included:</p> <p>Resident #7 was admitted to the facility on 7/12/13 with diagnoses which included multiple sclerosis, pneumonia and congestive heart failure.</p> <p>The resident's 1/1/15 recapitulation Physician Order Report included an order for a Foley Catheter related to the diagnosis of end stage multiple sclerosis.</p>	F 441	<p>Monitors:</p> <p>DON or designee will observe all residents with foley catheters weekly times four and monthly times five to ensure proper infection control protocol is being followed. DON or designee will report findings at QA meeting and will make changes to the above plan of correction as needed.</p> <p>Date of Compliance</p> <p>03/03/2015</p>		

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

PRINTED: 02/18/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135080	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/30/2015
NAME OF PROVIDER OR SUPPLIER GRANGEVILLE HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 410 EAST NORTH SECOND STREET GRANGEVILLE, ID 83530		
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F 441	<p>Continued From page 19</p> <p>On 1/28/15 at 9:30 a.m. the resident was observed on her bed with the foley catheter bag attached to the side of the bed. The urinary drainage bag was observed to be more than 1/2 full of urine and resting on the mat on the floor.</p> <p>At 9:35 on 1/28/15 LN #2 was shown the exposed catheter bag and stated the catheter bag should not have been touching the floor mat.</p> <p>On 1/29/15 at 6:30 p.m. the Administrator and the DON were informed of the above concern. The facility provider no further information.</p>	F 441			

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001230	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/30/2015
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NAME OF PROVIDER OR SUPPLIER
GRANGEVILLE HEALTH & REHABILITATION C

STREET ADDRESS, CITY, STATE, ZIP CODE
**410 EAST NORTH SECOND STREET
GRANGEVILLE, ID 83530**

(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) COMPLETE DATE
C 000	16.03.02 INITIAL COMMENTS The following deficiencies were cited during the State licensure survey of your facility. The surveyors conducting the survey were: Rebecca Thomas, RN, Team Coordinator, and Sherri Case, LSW, QIDP	C 000		
C 125	02.100,03,c,ix Treated with Respect/Dignity ix. Is treated with consideration, respect and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; This Rule is not met as evidenced by: Please see F 241 as it pertains to resident dignity.	C 125	C-125 See F-241	RECEIVED APR 13 2015 FACILITY STANDARDS
C 361	02.108,07 Housekeeping Services and Equipment 07. Housekeeping Services and Equipment. Sufficient housekeeping and maintenance personnel and equipment shall be provided to maintain the interior and exterior of the facility in a safe, clean, orderly and attractive manner. This Rule is not met as evidenced by: Please refer to F 252 as it relates to attractive environment.	C 361	C- 361 See F-252	
C 393	02.120,04,b Staff Call System at Each Bed/Room b. A staff calling system shall be installed at each patient/resident bed and in each patient/resident toilet, bath and shower room. The staff call in the toilet, bath or shower room	C 393	C-393 See F-246	

Bureau of Facility Standards
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE



TITLE
Administrator

(X6) DATE
4/9/15

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001230	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/30/2015
NAME OF PROVIDER OR SUPPLIER GRANGEVILLE HEALTH & REHABILITATION C		STREET ADDRESS, CITY, STATE, ZIP CODE 410 EAST NORTH SECOND STREET GRANGEVILLE, ID 83530		
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C 393	Continued From page 1 shall be an emergency call. All calls shall register at the staff station and shall actuate a visible signal in the corridor at the patient's/resident's door. The activating mechanism within the patient's/resident's sleeping room shall be so located as to be readily accessible to the patient/resident at all times. This Rule is not met as evidenced by: Please refer to F246 as it relates to call light accessibility.	C 393		
C 650	02.150,01,a,vii Resident Care Practices vii. Resident care practices, i.e., catheter care, dressings, decubitus care, isolation procedures. This Rule is not met as evidenced by: Please refer to F441 as it pertains to foley care.	C 650	C-650 See F-441	
C 664	02.150,02,a Required Members of Committee a. Include the facility medical director, administrator, pharmacist, dietary services supervisor, director of nursing services, housekeeping services representative, and maintenance services representative. This Rule is not met as evidenced by: Based on staff interview and review of the Infection Control Committee meeting minutes, it was determined the facility failed to ensure a representative from each department was included and participated in the Infection Control Meetings. This failure had the potential to affect all residents, staff and visitors to the facility. Findings included:	C 664	C-664 Resident Specific: No specific residents identified. Other Residents: See Systemic Changes.	

Bureau of Facility Standards

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C 664	<p>Continued From page 2</p> <p>The Infection Control Protocol was reviewed on 1/29/15 at 11:30 AM, the DON provided the quarterly meeting sign in sheets. Upon review, it was determined the following departments did not have a representative who participated in the Infection Control Committee meetings: *Pharmacy, Housekeeping and Maintenance for the 1st, 2nd, and 4th Quarter; and, *Dietary, Housekeeping and Maintenance for the 3rd Quarter.</p> <p>On 1/29/15 at 11:30 AM, the DON was made aware of the concern and stated she would make sure each department had a representative in the future.</p> <p>On 1/29/15 at 6:36 PM, the Administrator and DON were made aware of the concern with the quarterly Infection Control Meetings. No further information was provided by the facility.</p>	C 664	<p>Systemic Changes:</p> <p>Grangeville Health and Rehabilitation will ensure a representative from each required department will be present for quarterly infection control meetings.</p> <p>Monitors:</p> <p>Administrator or designee will ensure all required departments will be present at each quarterly Infection Control Meeting. Administrator will review sign in sheet at each quarterly meeting and will make changes to the above plan of correction as needed.</p>	
C 782	<p>02.200,03,a,iv Reviewed and Revised</p> <p>iv. Reviewed and revised as needed to reflect the current needs of patients/residents and current goals to be accomplished; This Rule is not met as evidenced by: Please refer to F280 as it relates to reviewing and revising care plans.</p>	C 782	<p>Date of Compliance</p> <p>03/03/2015</p>	
C 784	<p>02.200,03,b Resident Needs Identified</p> <p>b. Patient/resident needs shall be recognized by nursing staff and nursing services shall be provided to assure that each patient/resident receives care necessary to meet his</p>	C 784	<p>C-782</p> <p>See F-280</p>	

Bureau of Facility Standards

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NAME OF PROVIDER OR SUPPLIER GRANGEVILLE HEALTH & REHABILITATION C		STREET ADDRESS, CITY, STATE, ZIP CODE 410 EAST NORTH SECOND STREET GRANGEVILLE, ID 83530		
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C 784	Continued From page 3 total needs. Care shall include, but is not limited to: This Rule is not met as evidenced by: Please refer to F-309 as it relates to BG interventions and rechecks.	C 784	C-784 See F-309	
C 811	02.200,04,g,vii Medication Errors Reported to Physician vii. Medication errors (which shall be reported to the charge nurse and attending physician. This Rule is not met as evidenced by: Please refer to F-332 as it relates to medication errors.	C 811	C-811 See F-332	