



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

June 3, 2015

Chase J. Gunderson, Administrator
Owyhee Health & Rehabilitation Center
108 West Owyhee, PO Box A
Homedale, ID 83628-2040

Provider #: 135087

Dear Mr. Gunderson:

On **May 22, 2015**, a survey was conducted at Owyhee 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. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct." **Please provide ONLY ONE completion date for each federal and state tag (if applicable) in column (X5) Completion Date** to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **June 16, 2015**. Failure to submit an acceptable PoC by **June 16, 2015**, may result in the imposition of civil monetary penalties by **July 6, 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; and
- Include dates when corrective action will be completed in column (X5).

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

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

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

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **June 26, 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 **June 26, 2015**. A change in the seriousness of the deficiencies on **June 26, 2015**, may result in a change

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in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **June 26, 2015** includes the following:

Denial of payment for new admissions effective **August 22, 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 non-compliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **November 22, 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 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 **May 22, 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 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:

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

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

- BFS Letters (06/30/11)

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

This request must be received by **June 16, 2015**. If your request for informal dispute resolution is received after **June 16, 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 David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, Option 2.

Sincerely,



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

DS/dmj
Enclosures

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

PRINTED: 06/01/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135087	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/22/2015
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NAME OF PROVIDER OR SUPPLIER OWYHEE HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 108 WEST OWYHEE HOMEDALE, ID 83628
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(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
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F 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the annual federal recertification survey of your facility.</p> <p>The surveyors conducting the survey were: Lorraine Hutton, RN, Team Coordinator Linda Kelly, RN Kendra Deines RN, BSN</p> <p>The survey team entered the facility on May 18, 2015 and exited on May 22, 2015.</p> <p>Survey Definitions: ADL = Activities of Daily Living BIMS = Brief Interview for Mental Status CNA = Certified Nurse Aide DON = Director of Nursing LN = Licensed Nurse MAR = Medication Administration Record TAR = Treatment Administration Record MDS = Minimum Data Set assessment PRN = As Needed</p>	F 000	<p>"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Owyhee Health and Rehab does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."</p> <p>RECEIVED AUG 17 2015 FACILITY STANDARDS</p>	
F 159 SS=C	<p>483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS</p> <p>Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.</p> <p>The facility must deposit any resident's personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a</p>	F 159	<p>F159</p> <p>Corrective Actions: Resident 2, 5 and 8 have been notified in writing the availability of petty cash funds of less than \$50.00 for Medicaid and \$100.00 for Medicare.</p> <p>Identification of others affected and corrective actions: Facility reviewed all residents to identify any that have not been made aware and they or their representatives have been notified in writing of the availability of petty cash funds of those residents who elect the facility handle their personal funds .</p>	

LABORATORY DIRECTOR OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Chade Thompson</i>	TITLE ADMINISTRATOR	(X6) DATE 8/17/15
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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 159	Continued From page 1 separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed \$50 in a non-interest bearing account, interest-bearing account, or petty cash fund. The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative. The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches \$200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure the Admission Packet, Admission Agreement and/or Resident Right's Statement provided to residents	F 159	Measures to ensure that the deficient practice does not happen again: The facility admission agreement has been amended to reflect petty cash availability for residents electing the facility handle their personal funds and was issued to all new residents entering the facility on beginning May 21, 2015. Monitor corrective actions: BOM will audit new resident's admission agreement to ensure the resident was notified of petty cash fund availability 1 x week for 4 weeks. The audit results will be brought to the next QA meeting. Audits to begin on June 22, 2015. Corrective Actions will be completed	6/29/15

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F 159	Continued From page 2 upon admission addressed the availability of petty cash funds for residents who authorized the facility to hold, safeguard, and manage their personal funds. This was true for 3 of 10 sampled residents (#s 2, 5, & 8). The failure to notify the residents, in writing, of the availability of petty cash funds of less than \$50 for Medicaid residents and \$100 for Medicare residents on the same day of their request had the potential to limit residents' reasonable access to their personal funds. Findings include: Federal regulations are intended to assure that residents have access to \$50.00 (\$100.00 for Medicare residents) in cash within a reasonable period of time. Requests for less than \$50.00 (\$100.00 for Medicare residents) should be honored within the same day. Requests for \$50.00 (\$100.00 for Medicare residents) or more should be honored within three banking days. Although the facility need not maintain \$50.00 (\$100.00 for Medicare residents) per resident on its premises, it is expected to maintain amounts of petty cash on hand that may be required by residents. During the review of the information provided to residents in their admission packet, an explanation of the availability of petty cash funds for residents who entrusted their personal funds to the facility was not found. The Resident Trust section of the Admission Agreement stated residents could choose the facility to handle their personal funds; funds in excess of \$50/\$100, would be held in interest bearing accounts; an accounting of the trust would be available at any time; a statement mailed quarterly, etc. However, the Admission Agreement did not address how residents could access the funds and/or the availability of petty cash. Neither the Resident's Bill of Rights nor the New Resident Handbook	F 159		

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F 159	Continued From page 3 addressed the availability of petty cash. On 5/20/15 at 10:30 AM, the business office manager (BOM) was interviewed regarding how residents access petty cash. The BOM stated petty cash funds were kept in the business office at all times. During hours the business office was closed, the medication nurses had a key to the business office and the petty cash box. When asked if the availability of petty cash funds was documented in the admission packet/resident rights, the BOM stated it was documented on the Admission Agreement. On 5/20/15 at 10:45 AM, the Administrator was interviewed regarding the admission packet and asked where in the packet the issue of petty cash availability was documented. The Administrator stated he had reviewed the admission packet and had not found any written information on the availability of petty cash funds. He stated it was not in the Admission Agreement. On 5/22/15 at 11:30 AM, the BOM provided a list of 4 residents who entrusted their personal funds to the facility. Three of the four residents (#s 2, 5, and 8) were part of the survey sample selection. Resident #s 2 and 8 were not reliably interviewable, and Resident #5 primarily spoke Spanish. Although Resident #5 was alert and oriented to person and place, when asked (in Spanish) how he could acquire \$50 or less if needed, Resident #5 smiled and shrugged his shoulders. He offered no further comment upon prompts. On 5/22/15 at 1:00 PM, the Administrator and DON were notified of the citation.	F 159		
F 253 SS=C	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and	F 253	F 253 Corrective Actions: The radiator covers in residents #1's and #6's room were re-aligned, connected and cleaned. The baseboard heater in the hallway across from rooms 1-5 was cleaned and the cover was repaired. All resident rooms with vents or heaters as well as every facility vent and heater was audited for alignment, connection, and cleanliness. Identification of others affected and corrective actions: Residents in rooms 1-5 and anyone in that hallway could have been affected. Anyone with a vent or heater could have been affected.	

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F 253	<p>Continued From page 4</p> <p>maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, it was determined the facility failed to maintain an orderly and comfortable interior. This was true for Residents #1 and #6, when their radiator vent cover was disconnected from the unit, and anyone in the "old wing" hallway. Findings include:</p> <p>1. On 5/18/15 at 3:10 p.m., the cover over the radiator in Residents #1's and #6's room was observed misaligned and disconnected in the middle and right side. The radiator was at the end of Resident #1's bed, visible to both residents in the room and anyone passing by in the hallway.</p> <p>On 5/22/15 at 8:45 a.m., the Director of Maintenance was asked about the cover. He pushed on the middle panel of the cover to align it with the rest and stated, "It must have gotten hit with the bed."</p> <p>2. On 5/18/15 at 2:35 p.m., a long baseboard heater across from rooms 1 through 5 (and spanning the length of these rooms) was observed with a wavy cover and a rusty, dusty interior.</p> <p>On 5/22/15 at 9:00 a.m., the Director of Maintenance was asked about the dust and warped cover, to which he stated it was a working heater and that, "The inside isn't cleaned that much, we use a shop vac [vacuum] on it every once in while. The cover is all bent up, wish we</p>	F 253	<p>Measures to ensure that the deficient practice does not happen again: Maintenance director will fix the radiator covers and alignment of both the baseboard heaters and vents and repair the baseboard heater covers. Maintenance director will add "check radiator vents and baseboard heaters" on his quarterly maintenance log. Housekeeping will add "clean baseboard heaters and radiator vents" to their cleaning list. Housekeeping will clean all vents and heaters at least twice monthly and report any issues to the plant manager.</p> <p>Monitor corrective actions: Maintenance director will audit the baseboard heaters, radiator covers, vents for alignment, attachment and cleanliness for all vents and heaters in the facility twice monthly beginning 6/16/15 for two months and then quarterly ongoing. Corrective Actions will be completed</p>	6/16/15	

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F 253	Continued From page 5 could replace it."	F 253		
F 309 SS=E	<p>On 5/22/15 at 1:30 p.m., the Administrator and DON were notified of this issue. The facility did not provide any further information.</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review, it was determined the facility failed to provide oral fluids without straws as care planned and sliding scale insulin as ordered. This was true for 3 of 10 sampled residents (#s 5, 6, & 8). The failure created the potential for more than minimal harm when Resident #8's risk of aspiration of fluids was increased, and Resident #5 and Resident #6's hyperglycemia was not treated. Findings included:</p> <p>1. Resident #8 was admitted to the facility in 2009 with multiple diagnoses including epilepsy, cerebrovascular accident, and dysphagia.</p> <p>The resident's nutritional care plan documented "no straws" as an intervention initiated on 2/5/15.</p> <p>A 3/2/15 Speech Therapy Consultation</p>	F 309	<p>F 309</p> <p>Corrective Actions: Res #8 no longer has a straw at the dining table, resident room or any other area where she may receive fluids. Staff has been educated on safe swallow technique per SLP as well as following the specific plan of care with aspiration risk. BG monitoring and corrective actions were reviewed with nursing staff. Licensed nurses were educated on review of BGs and use of corrective insulin. A BG monitoring log has been placed in a binder on each medication cart for review by DON or designee daily and LNs at shift change. Each BG order has been revised to reflect parameters for MD notification and links to any sliding scale insulin orders. The BG monitor has a place to document MD notification.</p> <p>Identification of others affected and corrective actions: All res who are care planned to not have straws or are at risk of aspiration may be at risk. DNS will review all Care Plans to identify any resident who should not have a straw for meals, aspiration risks and transfer needs.</p>	

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F 309	<p>Continued From page 6 .</p> <p>documented "safe swallow strategies" for the resident included "no straws." It also stated, "Patient advanced to thin liquids and tolerating well with utilization of safe swallow strategies."</p> <p>Note: The 2012 St. James Health Care Education module "Dysphagia diets and how to keep patients safe from aspiration" stated, "Straws make it easy to take a larger sip than is intended, which can reach the back of [the] throat faster than when a cup is used and not giving the patient time to properly swallow. This increases risk of aspiration of the fluid."</p> <p>On 5/20/15 from 5:30 p.m. to 5:50 p.m., the resident was observed in the dining room during the dinner meal service. CNA #4 sat by the resident; who she fed, and provided the resident with sips of thin water repeatedly through a straw during the 20 minute observation.</p> <p>2. Resident #6 was admitted to the facility on 10/15/14 with multiple diagnoses, including diabetes mellitus.</p> <p>The resident's care plan documented the goals of being free from any signs or symptoms of hyperglycemia (initiated 10/15/14). Care Plan interventions for this concern documented, "Diabetes medication as ordered by doctor."</p> <p>The Resident's May 2015 recapitulation of physician orders included: "**Blood glucose q [every] day at alternating times, & *Insulin Aspart Solution 100 unit/mL [milliliter] Inject as per sliding scale: 70-140 = 0 units no insulin; 141-175 = 2 units; 176-200 = 3 units ..."</p>	F 309	<p>Measures to ensure that the deficient practice does not happen again: Straws have been removed from dining tables, resident rooms, and any other area where residents may receive fluids. Staff will ask kitchen staff for a straw as a second check for residents with orders to not have straws. A list of residents who should not have straws has been placed in the kitchen as well as binders on the med carts. The alert charting form will have a check off column added when MD is notified.</p> <p>Licensed nurses were educated on review of BGs and use of corrective insulin. A BG monitoring log has been placed in a binder on each medication cart for review by DON and LNs at shift change. Each BG order has been revised to reflect parameters for MD notification and links to any sliding scale insulin orders.</p>

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F 309	Continued From page 7 Note: Insulin lowers glucose levels in the blood when they are too high. The ADA's article, Hyperglycemia (High Blood Glucose), last edited 9/16/14, defined hyperglycemia as, "...technical term for high blood glucose (blood sugar)...happens when the body has too little insulin or when the body can't use insulin properly... Checking your blood and then treating high blood glucose early will help...avoid problems associated with hyperglycemia...Hyperglycemia can be a serious problem...fail to treat hyperglycemia [with insulin], a condition called ketoacidosis...could occur...Ketoacidosis is life-threatening and needs immediate treatment..." The March 2015 MAR documented three instances when the resident's blood glucose (BG) was over 140 mg/dl; the physician-ordered sliding scale insulin should have been, but was not, administered to lower the resident's blood glucose levels. There were also four instances in April, according to the resident's MAR, seven instances in May, according to the MAR, when sliding scale insulin should have been, but was not administered. On 5/19/15, when asked about the resident's sliding scale insulin for BGs over 140, the DON stated, "I am not even going to try to prove its there, its not. We already notified the doctor that there are medication errors." On 5/22/15 at 1:30 p.m., the Administrator and DON were notified of these issues. No further information was provided by the facility.	F 309	Monitor corrective actions: DNS or designee will review alert charting for MD notification and report results to QA for 2 months. Dietary will do a random observation of the dining room to compare straw use matches care plans. Dietary audit results will be brought to QA for 2 months. Each individual BG order was updated to included parameters for MD notification. All BGs will be monitored, with monitoring of corrective insulin administration, as ordered. This will be monitored weekly for eight weeks and then monthly on-going per director of nursing. Corrective Actions will be completed	6/16/15	

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F 309	<p>Continued From page 8</p> <p>3. Resident #5 was readmitted to the facility on 2/25/15 with diagnoses including Diabetes Mellitus, idiopathic peripheral neuropathy, hyposmolality and/or hyponatremia, psychosis, and psychotic disorder with delusions.</p> <p>The resident's significant change MDS, dated 3/10/15, documented the resident was moderately cognitively impaired, had diabetes as a health condition, and received insulin on a daily basis.</p> <p>The resident's 3/19/15 physician's orders instructed staff to monitor the resident's BGs (Blood Glucose) every day at alternating times: every 4 days on mornings, every 4 days on afternoons, and every 4 days at bedtime. The orders also included "Lantus Insulin 18 units at bedtime, Humulin R insulin 13 units with meals, and Humulin R per sliding scale: If BG was "0.0 - 250 = 0 units; 251-300 = 2 units; 301 -350 = 4 units; 351 - 400 = 6 units; 401 plus = 8 units. Call MD [physician] if BG is below 70 or above 400."</p> <p>Review of Weights and Vitals Summary reports for April and May 2015 revealed Resident #5's BG readings were above 250 on 6 of 45 days: * 4/12/15 at 6:30 AM - BG = 280 * 4/15/15 at 11:30 AM - BG = 260 * 4/26/15 at 8:30 PM - BG = 254 * 5/04/15 at 9:15 PM - BG = 258 * 5/05/15 at 11:07 AM - BG = 375 * 5/11/15 at 5:30 PM - BG = 287.</p> <p>The corresponding MARs for April and May 2015 documented the resident received sliding scale insulin as ordered by the physician on 5 of the 6 days listed above. However, no sliding scale insulin was documented as administered on</p>	F 309		

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F 309	Continued From page 9 4/15/15 at 11:30 AM when the resident's BG was 260. In addition there was no documentation on the eMAR or in the resident's April progress notes documenting why the sliding scale insulin was not given as ordered on 4/15/15. During an interview on 5/21/15 at 2:40 PM, the DNS was asked about the omission of sliding scale insulin on 4/15/15 at 11:30 AM. The DON later returned with second copy of the April MAR verifying the insulin was not documented as given. The DON stated a reason for the omission was not documented. The DON commented it looked like it had just been "missed."	F 309			
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES 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 observations and staff interviews, it was determined the facility failed to ensure: *Handrails were accessible; *Over-the-counter (OTC) medications were stored in locked areas; and *A resident was transferred as care planned. This was true for 2 of 9 sampled residents (#1 & #7), one random resident (#11), any resident who needed access to handrails to ambulate in hallways, and any independently mobile and	F 323	Corrective Actions: Med and treatment carts will be moved at least every 30 minutes and stored when not in use. All licensed nurses were in-serviced on moving the nursing carts at least every 30 minutes on 6/16/15. All new licensed nurses will be in-serviced on moving the nurse's carts during orientation. Carts will be stored in the storage room adjacent to the bathroom while not in use. The door to the storage room adjacent to the business office will be place on self-closing hinges with an auto-locking door handle with keypad code. The bio freeze found in the therapy gym will be placed in the storage room adjacent to the business office. Education was provided to all nursing staff on following each resident's individual POC on 6/2/15 and 6/16/15. Each resident's individual plan of care includes the type of transfer needed and amount of assist required. Staff was in-serviced on Resident #1 in regard to his specific type of transfer.		

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F 323	<p>Continued From page 10</p> <p>cognitively impaired resident who could access a storage room adjacent to the business office. This failure created the potential for more than minimal harm:</p> <p>*For Resident #1, #7, #11, or any resident who needed access to handrails to ambulate; *For any independently mobile cognitively impaired residents at risk for consuming unsecured OTC medications in the storage room; and *For Resident #1, who sustained a fall attempting to self transfer.</p> <p>Findings included:</p> <p>1. a) The medication cart stationed underneath a large mirror was observed blocking the handrail on the wall across from Room 7 on: *5/18/15 at 9:45 a.m., 11:25 a.m., 12:40 p.m., 1:00 p.m., 2:35 p.m., & 4:10 p.m. *5/19/15 at 9:18 a.m., 12:00 p.m., 12:35 p.m., 3:45 p.m. *5/20/15 at 11:05 a.m. *5/21/15 at 10:20 a.m.</p> <p>b) A treatment cart was observed blocking the handrail on the wall across from Room 9 on: *5/18/15 at 4:10 p.m. *5/19/15 at 8:58 a.m., 9:18 a.m., 12:00 p.m., 12:35 p.m., & 3:45 p.m. *5/20/15 at 11:05 a.m. *5/21/15 at 10:20 a.m.</p> <p>c) A second treatment cart stationed adjacent to the beauty parlor was observed blocking the handrail on: *5/18/15 at 11:25 a.m., 12:40 p.m., 1:00 p.m., 2:35 p.m., & 4:10 p.m. *5/19/15 at 8:58 a.m., 9:18 a.m., 12:00 p.m., 12:35 p.m., & 3:45 p.m.</p>	F 323	<p>Identification of others affected and corrective actions:</p> <p>All residents using handrails may have been affected.</p> <p>All residents that use the gym or go by the storage room could have been affected.</p> <p>All residents requiring transfer assist may have been affected.</p> <p>Measures to ensure that the deficient practice does not happen again:</p> <p>Med and treatment carts will be moved by the licensed nurses at least every 30 minutes. Carts will be stored in the storage room adjacent to the employee bathroom while not in use.</p> <p>Maintenance director will install self-closing hinges and auto-locking door handle with keypad entry on storage room door. Staff will be required to keep bio freeze in the storage room when not in use.</p> <p>Nursing staff will be in-serviced, monthly, on how to access each resident's personal care plan. Individual resident plans of care are located at each of three kiosks located within the facility. All new staff will be educated on this information, prior to working independently. In addition, individual kardex notebook is located at the man nurse station, should a kiosk be unavailable. Staff has 24 hour access to plans of care per kiosk and on paper.</p>

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F 323	Continued From page 11 *5/20/15 at 11:05 a.m. *5/21/15 at 10:20 a.m. On 5/18/15 at 4:10 p.m., Resident #1 was observed using handrails to ambulate with his walker. On 5/18/15 at 4:10 p.m., Resident #11 was observed using the handrail to ambulate down the hall from Room 20 to Room 7. On 5/20/15 at 11:35 a.m., Resident #7 was observed using handrails to ambulate. On 5/21/15 at 5:15 p.m., the Administrator was informed of the handrails blocked by carts. The administrator acknowledged that carts were stationed in hallways. He stated the battery on the computer on the medication cart did not hold a charge, and the medication cart had to stay in that spot to access the nearby electrical outlet. 2. On 5/18/15 at 1:35 p.m., a storage room adjacent to the business office was observed unlocked with the following over-the-counter medications inside: *20 tubes of anti-fungal cream *20 bottles of Dermaklenz wound cleanser *1 bottle of hydrogen peroxide *3 boxes (with 144 packets each) of bacitracin zinc oxide At 1:50 p.m., LN #1 was about to lock the storage room door. When asked if the storage room door was supposed to be locked, she stated, "Yes, I saw the door open." 3. On 5/18/15 at 3:35 p.m., the therapy gym door was open, but no staff were in the room, where	F 323	Monitor corrective actions: Director of nursing or designee will audit the placement of the nurse carts four times daily for four weeks and twice daily for eight weeks. Maintenance director will audit storage room door weekly for four weeks to ensure door is shutting and locking with new self-closing hinges and auto-locking door handle. Audits to begin on 6/22/15. Results will be reported during next QA meeting. Director of Rehab will in-service all therapy staff on keeping bio freeze in the storage room adjacent to the business office. He will audit the bio freeze being kept in the storage room weekly for four weeks. The results will be reported during the next QA meeting. Audits will begin on 6/22/15. Director of nursing or designee will do random monitoring of resident transfers twice daily on different shifts for two weeks then weekly for eight weeks. If non-compliance with care plan is observed, education will be immediately provided. Resident care plans will be reviewed at least quarterly with appropriate changes made. The changes will be reflected in the available care plan per the kiosk and on paper. Corrective Actions will be completed	6/22/15

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F 323	<p>Continued From page 12</p> <p>two bottles (32 oz and 3 oz) of Biofreeze therapy pain reliever were found in an unlocked closet.</p> <p>Note: Biofreeze pain reliever had the warning level, "For external use only."</p> <p>On 5/18/15 at 4:10 p.m., the Occupational Therapist (OT) was asked how Biofreeze was stored. The OT said Biofreeze was stored in a locked closet, but when shown the Biofreeze in the unlocked closet, the OT said it should have been in the locked closet.</p> <p>On 5/21/15 at 10:00 a.m., the Director of Rehabilitation stated, "The Biofreeze should have been in the locked cabinet and the door [to the therapy room] should have been locked."</p> <p>On 5/22/15 at 1:30 p.m., the Administrator and DON were notified of these issues. No further information was provided on these issues.</p> <p>4. Resident #1 was admitted to the facility 12/1/14 with multiple diagnoses, including difficulty walking and muscle weakness.</p> <p>The 2/25/15 quarterly MDS documented the resident required extensive one-person assistance with transfers and toileting.</p> <p>The resident's care plan documented the resident fell on 12/6/14 attempting to self-transfer to the toilet.</p> <p>The resident's ADL Self Performance care plan, dated 11/24/14, documented, "Requires 1 staff assist with transferring."</p> <p>On 5/19/15 at 8:45 a.m., the resident was</p>	F 323			

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F 323	Continued From page 13 observed as he self-propelled his wheelchair (w/c) into his room and shut the door. Moments later, the chair alarm was heard by two surveyors in the hall. Almost immediately, CNA #2 arrived, went into the resident's room, and turned off the alarm. With the resident's permission, the two surveyors entered the room, where the resident and w/c were observed behind the bathroom curtain. CNA #2 was asked if the resident was already on the toilet when she arrived in the room, to which the CNA responded, "Yes." The CNA then stood by as the resident self transferred from the toilet back into his w/c. When asked how much transfer assistance the resident required, the CNA stated, "He is a self-transfer with supervision."	F 323			
F 328 SS=D	On 5/22/15 at 1:30 p.m., the Administrator and DON were notified of these issues. No further information was provided by the facility. 483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by:	F 328	Corrective Actions: The MD order for resident #2 was corrected to include parameters for use, specific goals, and for monitoring that the correct O2 flow is being used. Identification of others affected and corrective actions: All residents with oxygen orders have the potential to be affected. All oxygen orders and supportive documentation were reviewed by director of nursing. No adverse outcomes identified.		

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F 328	<p>Continued From page 14</p> <p>Based on observation, record review and staff interview, it was determined the facility failed to ensure a resident's oxygen order was complete and provided guidance to staff regarding oxygen blood-oxygen concentration goals and liter flow adjusted to the goal. This affected 1 of 2 sampled residents (#2) reviewed for respiratory services/ oxygen therapy. The lack of clear physician orders for oxygen therapy had the potential to affect the resident's respiratory status.</p> <p>The findings included:</p> <p>Perry & Potter's, Clinical Nursing Skills & Techniques, 7th Edition, 2010, stated on p. 629, "Treat oxygen therapy as a medication...As with any drug, continuously monitor the dosage or concentration of oxygen. Routinely check the health care provider's orders to verify that the patient is receiving the prescribed oxygen concentration. The six rights of medication administration also pertain to oxygen administration [Right patient, right medication, right dose, right mode, right time]."</p> <p>Resident #2 was last admitted to the facility on 7/25/13 with diagnoses that included chronic airway obstruction (COPD), cerebrovascular disease, adjustment disorder with anxiety, and Alzheimer's disease.</p> <p>The resident's current physician's orders, reviewed by the resident's physician on 4/20/15, documented, "Oxygen 1 - 4 L/M [liters per minute] per nasal cannula PRN [as needed]. Check O2 sats [SPO2] PRN for S/S [signs /symptoms] COPD." Note: The physician's order did not provide direction to nurses regarding the goal SPO2 level (i.e. maintain O2 sats over 90 %).</p>	F 328	<p>Measures to ensure that the deficient practice does not happen again: All licensed nurses were in-serviced on 6/16/15 on the components of a complete O2 order. A policy and procedure for the administration of oxygen was adopted, revised and reviewed, which states that only a LN will be responsible for the application of O2. Documentation of the O2 administration and outcome will be documented in the medical record per the LN applying the O2.</p> <p>Monitor corrective actions: Oxygen orders reviewed on all residents and are monitored weekly by director of nursing beginning 6/16/15, to ensure that the order is specific and that the appropriate documentation is in place. Audits will continue weekly for three months and reviewed on recaps monthly per Dr. Brown.</p> <p>Corrective Actions will be completed</p>	6/16/15	

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F 328	<p>Continued From page 15</p> <p>The physician also ordered: * Advair Discus Aerosol powder Activated 500 -50 MCG dose 1 puff inhalation TWICE A DAY..." * "DuoNeb Solution 0.5 - 2.5 (3) MG/ML [milligram per milliliter] 1 dose inhale orally every 6 hours as needed for SOB [shortness of breath]."</p> <p>Resident #2's current Care Plan, revised on 4/27/15, had as focus areas: 1. "Has emphysema/COPD..." with a goal, "Will be free of s/sx [signs/symptoms] of respiratory infections through review date ..." Interventions included: - Give aerosol or bronchodilator as ordered. Monitor/document any side effects and effectiveness - Give oxygen therapy as ordered -Monitor for difficulty breathing (dyspnea), acute respiratory insufficiency, anxiety ..."</p> <p>2. "Has oxygen therapy r/t [related to] COPD ..." with a goal of, "Will have no s/sx of poor oxygen absorption through review date..." Interventions included: - "Give medications as ordered by physician. Monitor/document effectiveness and side effects. - Monitor for s/sx of respiratory distress and report to MD PRN: Respirations, Pulse Oximetry, tachycardia, skin color..." and, - O2 (oxygen) as ordered by physician ..."</p> <p>SPO2 parameters for oxygen administration were not addressed in either focus area of the 4/27/15 Care Plan.</p> <p>The resident's April 2015 and May 2015 MAR: documented, "Oxygen 1 - 4 L/M per nasal cannula PRN. Check O2 sats PRN for S/S COPD." The MAR contained boxes for each day</p>	F 328			

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F 328	<p>Continued From page 16</p> <p>of the month for monitoring the oxygen placement and liter flow rate. The MAR did not have a box in which to document the resident's SPO2 (oxygen level) and did not address SPO2 parameters for oxygen administration.</p> <p>On 5/18/15 at 9:00 AM , 10:30 AM, 1:15 PM, and 3:00 PM, Resident #2 was observed in her room, hallway, and dining room. The resident did not have oxygen in place during the two morning observations, but did not appear short of breath, restless, or anxious. At 1:15 PM and 3:00 PM she was observed in bed with oxygen on. The liter flow was at 2.5 liter/minutes per nasal cannula. Resident #2 was observed throughout the day on 5/19/15 and 5/20/15. The resident was not observed with oxygen on during these visits.</p> <p>Medication administration (eMAR) notes for 5/18/15 documented the resident's oxygen level was 88 % at 11:15 AM and she was placed on 2 liters of oxygen. Other than the documented SPO2 level, neither the eMar nor other nursing progress notes documented signs or symptoms of respiratory distress, dyspnea, signs of COPD, or what caused the nurse to check the resident's SPO2 and place her on oxygen. The last eMAR or progress note entry for 5/18/15 was made at 11:25 AM. The note documented the resident's SPO2 was at 94% on 2 liters of oxygen and the treatment was "effective." There was no further documentation regarding oxygen administration between 5/18/15 and 5/20/15, including when/why the oxygen liter flow was adjusted to 2.5 liters, when the oxygen was removed, or the resident's SPO2 level and respiratory status when the oxygen was removed.</p> <p>On 5/18/15 at 1:30 PM, LN #2 was asked why</p>	F 328			

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F 328	<p>Continued From page 17</p> <p>Resident #2 was placed on oxygen at 11:15 AM. LN #2 stated the resident, "Just did not look right; I checked her oxygen level and it was low so I put her on oxygen." When asked what parameters the resident's physician had provided for oxygen levels, LN #2 looked at the resident's MAR and stated she did not see any parameters, but stated the nurses "knew" to keep the sats above 90%.</p> <p>On 5/21/15 at 3:30 pm, the DON was interviewed regarding Resident #2's oxygen order. The DON stated she was not sure why a parameter was not given by the physician, but that nursing staff "know" to check the resident for shortness of breath, dyspnea, anxiety, and other signs and symptoms throughout the day. If the resident "looks off" or was showing signs and symptoms of difficulty breathing, the nurses were to check her oxygen level and administer oxygen if the resident's SPO2 was under 90%. When asked if the nurses had attempted to clarify the order, the DON stated there was no documentation of an order clarification.</p> <p>On 5/22/15 at 1:00 PM the DON and Administrator were notified of the citation.</p>	F 328			

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001660	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/22/2015
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NAME OF PROVIDER OR SUPPLIER
OWYHEE HEALTH & REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
108 WEST OWYHEE
HOMEDALE, ID 83628

(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
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C 000 16.03.02 INITIAL COMMENTS

The following deficiencies were cited during the annual state licensure survey of your facility.

The surveyors conducting the survey were:
Lorraine Hutton, RN, Team Coordinator
Linda Kelly, RN
Kendra Deines RN, BSN

C 000

C 422 02.120.05,p,vii Capacity Requirments for Toilets/Bath Areas

vii. On each patient/resident floor or nursing unit there shall be at least one (1) tub or shower for every twelve (12) licensed beds; one (1) toilet for every eight (8) licensed beds; and one (1) lavatory with mirror for every eight (8) licensed beds. Tubs, showers, and lavatories shall be connected to hot and cold running water.

This Rule is not met as evidenced by:
Based on observation and staff interview, it was determined the facility did not provide one tub or shower for every 12 licensed beds. Findings included:

C 422

C 422

This facility requests the continuance of the waiver that has existed for many years in this facility.

We are short two shower/bath rooms. To ensure it does not negatively affect our residents we employ dedicated bath aides to ensure that all showers and baths are scheduled and executed for each resident according to their choice and preference. We talk about it at resident council and survey residents to verify outcomes are positive. No residents have been negatively affected by the number of shower rooms.

We are licensed for 49 beds but our ADC for the past year is 31 with a high of 36.

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FACILITY STANDARDS

On 5/22/15 at 8:30 a.m., the Maintenance Supervisor (MS) accompanied two surveyors during the General Observations of the Facility tour. The MS showed the surveyors the main shower room, which had a tub and 2 shower stalls. However, only one of the shower stalls had plumbing. The MS said residents did not use the tub, but did use only the one shower stall with plumbing. When asked if there were any other bathing areas, the MS showed the surveyors a bathtub in the bathroom for Rooms 6 and 7. The

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

Chad Henderson

TITLE

ADMINISTRATOR

(X6) DATE

8/17/15

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001660	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/22/2015
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NAME OF PROVIDER OR SUPPLIER: Owyhee Health & Rehabilitation Center
STREET ADDRESS, CITY, STATE, ZIP CODE: 108 WEST OWYHEE HOMEDALE, ID 83628

(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
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C 422	Continued From page 1 MS said that tub was "rarely" used by residents. The facility was licensed for 49 beds, however the two tubs and one shower met the requirement for only 36 beds. On 5/28/14 at 10:30 a.m., the Administrator requested to continue a waiver for the bathing facilities.	C 422		
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 Infection Control Committee (ICC) attendance records, it was determined the facility failed to ensure a pharmacist and maintenance services representative participated in ICC meetings at least quarterly. The lack of participation of all ICC members created the potential for negative outcomes for residents, visitors, and staff in the facility. Findings included: On 5/21/15 at 10:50 am, the Infection Control Nurse (ICN) was interviewed about the facility's infection control program. A few moments later, the Administrator joined the interview. When asked about ICC meetings, the Administrator said the ICC met quarterly during Quality Assurance meetings. The Administrator said that he, the Medical Director, the Director of Nursing Services and the Dietary Manager, who also supervised housekeeping, attended the ICC meetings. The	C 664	C 664 Corrective Actions: ICC meetings will be attended quarterly by the facility medical director, administrator, pharmacist, dietary services supervisor, director of nursing services, housekeeping services representative, and maintenance services representative. Identification of others affected and corrective actions: All residents in the facility could have been affected. Measures to ensure that the deficient practice does not happen again: The administrator in-serviced all required ICC members on 6/16/15 and will ensure they are present for all ICC meetings. All required committee members will sign in at all ICC meetings. Monitor corrective actions: Administrator will check attendance record for each ICC meeting to verify attendance by all required members. First meeting will be held on 7/13/15. Corrective Actions will be completed	6/16/15

Bureau of Facility Standards

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NAME OF PROVIDER OR SUPPLIER OWYHEE HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 108 WEST OWYHEE HOMEDALE, ID 83628
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(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
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C 664	Continued From page 2 Administrator provided the ICC attendance records for October 2014, January 2015 and May 2015. Review of the records revealed that the pharmacist and a maintenance services representative had not attended any of the meetings, which the Administrator confirmed.	C 664		
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