



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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

DEBRA RANSOM, R.N., R.H.I.T., Chief  
BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, ID 83720-0009  
PHONE 208-334-6626  
FAX 208-364-1888

**CERTIFIED MAIL: 7012 1010 0002 0836 1758**

April 2, 2014

Arthur F. Gulden, Administrator  
Bingham Memorial Skilled Nursing & Rehabilitation  
98 Poplar Street  
Blackfoot, ID 83221-1758

Provider #: 135007

Dear Mr. Gulden:

On **March 19, 2014**, we conducted an on-site follow-up revisit to verify that your facility had achieved and maintained compliance. We had presumed, based on your allegation of compliance, that your facility was in substantial compliance as of **January 10, 2014**. However, based on our on-site follow-up revisit conducted **March 19, 2014**, we found that your facility is not in substantial compliance with the following participation requirements:

**F221 -- S/S: D -- 42 CFR §483.13(a) -- Right to be Free from Physical Restraints**  
**F329 -- S/S: E -- 42 CFR §483.25(l) -- Drug Regimen is Free from Unnecessary Drugs**

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.) **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

Arthur F. Gulden, Administrator

April 2, 2014

Page 2 of 4

Statement of Deficiencies and Plan of Correction, Form CMS-2567 and State Form, in the spaces provided and return the originals to this office.

Your copy of the Post-Certification Revisit Report, Form CMS-2567B, listing deficiencies that have been corrected is enclosed.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **April 15, 2014**.

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

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put in place or what systemic change will you make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice does not recur, i.e., what quality assurance program will be put into place. This monitoring will be reviewed at the follow-up survey as part of the process to verify that the facility has corrected the deficient practice. Monitoring must be documented and retained for the follow-up survey. In your Plan of Correction, please be sure to include:
  - a. Specify by job title who will do the monitoring.
    - \* It is important that the individual doing the monitoring have the appropriate experience and qualifications for the task.
    - \* The monitoring cannot be completed by the individual(s) whose work is under review.
  - b. Frequency of the monitoring; i.e., weekly x 4, then q 2 weeks x 4, then monthly x 3.
    - \* A plan for "random" audits will not be accepted.
    - \* Initial audits must be more frequent than monthly to meet the requirement for the follow-up.
  - c. Start date of the audits;
- Include dates when corrective action will be completed in column (X5).

Arthur F. Gulden, Administrator  
April 2, 2014  
Page 3 of 4

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*.

As noted in the letter of **December 23, 2013**, following the **Recertification, Complaint Investigation and State Licensure** survey of **December 9, 2013**, we have already made the recommendation to the Centers for Medicare and Medicaid Services (CMS) for Denial of Payment for New Admissions and termination of the provider agreement on **June 9, 2014**, if substantial compliance is not achieved by that time.

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

STATE ACTIONS effective with the date of this letter (**March 31, 2014**): None.

If you believe the deficiencies have been corrected, you may contact Lorene Kayser, L.S.W., Q.M.R.P., or David Scott, R.N., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance.

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

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

Arthur F. Gulden, Administrator  
April 2, 2014  
Page 4 of 4

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 **April 15, 2014**. If your request for informal dispute resolution is received after **April 15, 2014**, 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 on-site follow-up revisit. If you have any questions or concerns, please contact this office at (208) 334-6626.

Sincerely,

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

DS/dmj  
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  R-C 03/19/2014
NAME OF PROVIDER OR SUPPLIER  BINGHAM MEMORIAL SKILLED NURSING & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 98 POPLAR STREET BLACKFOOT, ID 83221	
(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 follow up visit for your annual Federal recertification and complaint investigation survey.  The surveyors conducting the survey were: Amy Barkley, RN, BSN, Team Coordinator Nina Sanderson, BSW, LSW  The survey team entered the facility on 3/17/14, and exited the facility on 3/19/14.  Survey Definitions: DNS = Director of Nursing Services IDT = Interdisciplinary Team MDS = Minimum Data Set PT = Physical Therapy w/c = wheelchair IDON = Interim Director of Nursing BID = Twice daily LSW = Licensed Social Worker	{F 000}	The following Plan of Correction is submitted by the facility in accordance with the pertinent terms and provisions of 42 CFR Section 488 and/or related state regulations, and is intended to serve as a credible allegation of our intent to correct the practices identified as deficient. The Plan of Correction should not be construed or interpreted as an admission that the deficiencies alleged did, in fact, exist; rather, the facility is filing this document in order to comply with its obligations as a provider participating in the Medicare/Medicaid program(s).	
{F 221} SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS  The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.  This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, it was determined the facility used physical restraints on residents without an identified medical condition which required the use of the restraint. Additionally, the facility failed to evaluate the use of less restrictive	{F 221}	<b>RECEIVED</b> <b>APR 30 2014</b> <b>FACILITY STANDARDS</b>  <u>F 221</u>  Corrective action for residents found to have been affected by this deficiency:  Pre-restraint assessment tool in place and used for any resident where restraints may be medically appropriate. Assessment tool is used by nursing and/or therapy to assess patient. Assessments then reviewed by nursing and therapy.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE Administrator (X6) DATE 4/28/14

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.

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

PRINTED: 03/31/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135007</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R-C</b> <b>03/19/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>BINGHAM MEMORIAL SKILLED NURSING &amp; REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>98 POPLAR STREET</b> <b>BLACKFOOT, ID 83221</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 221}	<p>Continued From page 1</p> <p>devices/restraints, other than a lap buddy for a cognitively impaired resident. This affected 1 of 2 (#23) residents sampled for the use of physical restraints. This practice created the potential for harm should the resident experience contractures, decreased mobility or the development of pressure sores from unnecessary restraint use. Findings include:</p> <p>F 221 was cited at the annual survey, on 12/9/2013. The Plan of Correction stated the facility would:</p> <ul style="list-style-type: none"> <li>* Establish and implement a restraint assessment tool to be used for any resident...</li> <li>* Restraint committee would follow up with restraint assessments a minimum of every 90 days and as needed by completing the physical assessment form and reviewing it with nursing and therapy.</li> </ul> <p>Resident #23 was admitted to the facility with multiple diagnoses to include, subdural hematomas, diabetes mellitus type II, dementia, and seizure disorder.</p> <p>The Resident's Quarterly MDS, dated 1/7/14, documented in part the following:</p> <ul style="list-style-type: none"> <li>* Problems with short term and long term memory;</li> <li>* Daily decision making skills poor; cues/supervision required;</li> <li>* Total assist of two people for bed mobility, transfers, and toilet use;</li> <li>* Total assist of one person for locomotion on and off the unit;</li> <li>* Impairment of bilateral upper and lower extremities.</li> <li>* Had a trunk restraint in use.</li> </ul>	{F 221}	<p>Resident #23 received IDT assessment and therapy evaluation to determine most appropriate and least restrictive wheelchair set up. Lap buddy kept in place as the least restrictive device that best promotes postural positioning and wheelchair independence and mobility. Resident #23 currently receiving therapy services to promote postural strengthening. Therapy evaluated patient with wedge cushion and also reclining wheelchair, but resident was unable to maintain proper position and/or interventions limited his wheelchair independence and inobility.</p> <p><b>Corrective action for residents that may be affected by this deficiency:</b></p> <p>All residents have the potential to be affected by these identified concerns.</p> <p>Pre-restraint assessment tool in place and used for any resident where restraints may be medically appropriate. Assessment tool is used by nursing and/or therapy to assess patient. Assessments then reviewed by nursing and therapy. If recommendation includes application of restraint family is contacted for consent and physician is consulted.</p> <p>Other residents with restraints assessed and evaluated. Documentation completed related to least restrictive device. Restraint committee will follow up with restraint assessments a minimum of every 90 days and as needed by completing the physical assessment form and reviewing it with nursing and therapy.</p> <p>Care plans will be updated related to any changes in restraints for residents.</p>	

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

PRINTED: 03/31/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  R-C 03/19/2014	
NAME OF PROVIDER OR SUPPLIER  BINGHAM MEMORIAL SKILLED NURSING & REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 98 POPLAR STREET BLACKFOOT, ID 83221		
(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 221}	<p>Continued From page 2</p> <p>The Resident's Restraint Care Plan, initiated on 1/16/14, documented the following:</p> <ul style="list-style-type: none"> <li>- Problem/Strength/Need area - "[Resident's name] is using the current restraint device and/or devices; lap buddy, low bed and has an accentuated risk of physical and/or psychological status related to the need for restraints due to, inability to control body positioning, seizures, weakness, recent falls, and history of falls out of wheelchair.</li> <li>- Benefits/Strengths for restraint use, enables resident to maintain proper body alignment and enhances wheelchair mobility.</li> <li>- Approach area documented in part the following: <ul style="list-style-type: none"> <li>- "...Ensure least restrictive methods have been tried and failed prior to implementation;</li> <li>- Restraint committee to assess for effectiveness and/or reduction as appropriate; quarterly and prn;</li> <li>- If agitated, reassure client that restraint is for protection and release if supervised to decrease agitation;</li> <li>- [Resident's name] cannot remove the lap buddy on command, has been assessed by Physical Therapy (PT) and found to be a restraint but needed for body positioning and alignment.</li> </ul> </li> </ul> <p>The Resident's Physical Restraint Assessment, dated 2/9/14, documented the resident was confused and he had a lap buddy (restraint) in use and the less restrictive measure tried was, "Removed lap buddy." The IDT recommended, "Needs lap buddy and continued assessment. Rehab screening every 3 months," for continued use of the restraint.</p> <p>The Resident's nursing progress notes documented the following:</p>	{F 221}	<p>In-service will be provided to nursing staff by Interim DON concerning proper procedures for restraints before 4/28/14</p> <p><b>Measures that will be put into place to ensure that this deficiency does not recur:</b></p> <p>Director of Nursing or Interim Director of Nursing will audit 5 residents weekly for a period of at least 12 weeks starting the week of 4/20 to ensure residents have been properly assessed and necessary documentation is in place related to medical condition and least restrictive device. Any issues will be reported to the QA committee.</p> <p>Restraint committee chaired by DON and consisting of at least nursing representative and therapy representative, usually Director of Rehab, meets at least every other week and as needed to review restraint information and assessments.</p> <p>Medical Director will review and approve facility policy related to restraints.</p> <p><b>Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:</b></p> <p>The QA committee will review any issues uncovered by weekly audits and after the initial 12 weeks make a determination related to changing the frequency of those audits. Additionally, QA committee will review facility progress on restraints at least quarterly on an on-going basis to aid in monitoring compliance and resident need.</p>	5/7/14

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

PRINTED: 03/31/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  R-C 03/19/2014	
NAME OF PROVIDER OR SUPPLIER  BINGHAM MEMORIAL SKILLED NURSING & REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 98 POPLAR STREET BLACKFOOT, ID 83221		
(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 221}	<p>Continued From page 3</p> <p>- 2/12/14, "Lap buddy removed for evaluation of need. Removed for 15 min in that time. Pt was unable to safely reposition himself in chair. Patient propels self short distances with the lap buddy in place but unable to safely propel safely [without] the lap buddy in place...Lap buddy removed during cares and meals."</p> <p>- 2/19/14, "Resident is unable to remove lap buddy on demand however he has the physical ability to remove the lap buddy. Once the lap buddy is removed his physical mobility decreases..."</p> <p>Note: The Resident's IDT Clinical Team Meeting notes, dated 3/10/14, documented the following, "Discussed [Resident's name] current use of a lap buddy to enhance postural positioning in his w/c. [Resident's name] is more mobile with his w/c and this is the least restrictive form. We have removed lap buddy to assess and he is much less able to maneuver in the w/c. His postural positioning is decreased significantly when lap buddy was removed..."</p> <p>On 3/18/14, at approximately 9:00 AM, the resident was observed sitting in the day room, in his wheelchair, with the lap buddy secured to his chair.</p> <p>On 3/19/14, at approximately 10:00 AM, the resident was observed sitting in the day room, in his wheelchair, with the lap buddy secured to his chair.</p> <p>On 3/19/14 at 11:50 PM, the Interim DNS, the charge nurse, and the Administrator were asked about Resident #23's lap buddy and the rationale for use. The charge nurse stated the facility did not try a less restrictive device prior to the lap</p>	{F 221}		

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

PRINTED: 03/31/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  R-C 03/19/2014
NAME OF PROVIDER OR SUPPLIER  BINGHAM MEMORIAL SKILLED NURSING & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 98 POPLAR STREET BLACKFOOT, ID 83221		
(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 221}	Continued From page 4 buddy. Additionally, when asked if a therapy screen had been submitted related to concerns about positioning, the Interim DNS and Charge nurse both indicated a screen had not been submitted to therapy. The Interim DNS and charge nurse were not able to say the resident's current seating system had been identified as the most appropriate for positioning, safety, and to promote and maintain as much independence as possible for the resident.  On 3/21/14, at 11:32 AM, additional information was received from the facility and did not resolve the issue.	{F 221}			
{F 329} SS=E	<b>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</b>  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 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.	{F 329}	<u>F329</u>  Medication regimen reviewed by pharmacist and IDT for resident 1. IDT completed evaluation of resident finding patient has exhibited hallucinations that are distressing related to her children and/or family being in danger. Clinical indication for Seroquel changed. GDR recommendation for med changes sent to attending physician. IDT evaluation completed to identify targeted behaviors to monitor and identify plan for patient.  Medication regimen reviewed by pharmacist and IDT for resident 3. IDT completed evaluation of resident finding patient has distressing delusions related to her husband being unfaithful to her. Geodon was dc'd. GDR recommendation for med changes sent to attending physician. Physician gave order to decrease Seroquel by 50mg and evaluate her progress. IDT evaluation completed to identify targeted behaviors to monitor and identify plan for patient.  Medication regimen reviewed by pharmacist for all residents on anti-psychotics and pharmacy recommendations sent to physicians. Pharmacy review and any recommendations to the physicians are based on individual monthly evaluations for each residents regarding psychotropic needs. Psychotropic meeting also held to analyze patient medications and pharmacy recommendations.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  R-C 03/19/2014
NAME OF PROVIDER OR SUPPLIER  BINGHAM MEMORIAL SKILLED NURSING & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 98 POPLAR STREET BLACKFOOT, ID 83221		
(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 329}	Continued From page 5  This REQUIREMENT is not met as evidenced by: Based on staff interview and record review it was determined the facility did not ensure residents were free from unnecessary medications. This was true for 2 of 2 residents (#s 1 and 3) sampled for antipsychotic medication use. The deficient practice had the potential to cause declines if residents experienced negative effects from receiving a medication for which there was no clear clinical indication. Findings included:  The facility was cited at F 329 during their annual recertification survey on 12/9/13. The facility's plan of correction documented they would in-service nursing administration, social services, nursing staff, and the pharmacist regarding psychotropic drug documentation; the pharmacist would review all resident medications every month and forward any recommendations to the physician; and the facility would hold a psychotropic meeting monthly to assess needs of residents and monitor individual psychotropic medications and reason for use.  1. Resident #1 was admitted to the facility on 1/13/12. At the time of survey, multiple medical conditions were noted including multisensory dementia and blindness.  Resident #1's most recent MDS assessment, dated 9/13/13, coded: *Long term and short term memory deficits with severely impaired decision making skills;	{F 329}	<b>Corrective action for residents that may be affected by this deficiency:</b>  All residents with psychotropic medications have the potential to be affected by these identified concerns.  Pharmacist will review patient medication regimens monthly and send any recommendations to physician including reasoning and rationale for recommendations. Psychotropic meeting will be held at least monthly with nursing, social services (or social services designee), and pharmacist to discuss pharmacy review, evaluate target behavior monitoring documentation, and validate defined reasons for using psychotropic medications for individual residents.  In-service will be provided to nursing staff concerning psychotropic drugs, documentation, behavior monitoring documentation, and plans developed for patients on anti-psychotic medications before 4/28/14.  Behavior tracking forms to be used identifying targeted behaviors for nursing staff to monitor developed by IDT identifying specific behaviors. Additionally, alert charting will be used for any new behaviors noted or for new anti-psychotic medication orders received for any resident from their attending physicians. Alert charting will be completed for at least 14 days for any new order for anti-psychotic medication.		

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

PRINTED: 03/31/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  R-C 03/19/2014
NAME OF PROVIDER OR SUPPLIER  BINGHAM MEMORIAL SKILLED NURSING & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 98 POPLAR STREET BLACKFOOT, ID 83221	
(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 329}	<p>Continued From page 6</p> <p>*Fluctuating cognition, per baseline for this resident;</p> <p>*No hallucinations or delusions; and</p> <p>*Daily behavioral symptoms, which did not compromise the safety of the resident or others, and did not disrupt the living environment.</p> <p>On 1/29/14, an Interdisciplinary Psychoactive Medication Review form for the resident documented the resident received Seroquel 50 milligrams twice daily for a diagnosis of dementia with hallucinations and agitated features. The, "Findings and Assessment" area of the form documented, "...dose reduced from 100 mg BID to 50 mg BID...staff reports patient chanting has significantly increased since dose decrease..." The "Psychoactive Medication and Interdisciplinary Recommendations" area of the form documented, "No medication recommendations at this time..." [NOTE: It was not clear from this form when the dosage reduction attempt had been made. The date on the resident's "Active Therapies" (Physician's Recapitulation Orders) for March 2014 documented the start date as "1/02", but no year was noted.]</p> <p>On 2/4/14, an "Initial Psychological Assessment" in the resident's record documented, "When looking at the psychotropic medication list which they provided, she is on Celexa, Trazodone, Seroquel, and lorazepam. The patient is also on hydrocodone for pain and gabapentin for pain...In observing the patient, she would open her eyes and chant or make statements about people or babies for a few minutes, and then close her eyes and keep making the statements. Then she would, after about 10 minutes, actually appear to go to sleep but then wake up with a start and</p>	{F 329}	<p>IDT will evaluate patients and develop plan that include non-pharmacological interventions for any residents on anti-psychotic medications in an effort to minimize the use of these medications and find alternative ways to help residents.</p> <p><b>Measures that will be put into place to ensure that this deficiency does not recur:</b></p> <p>Pharmacist will review all resident medications every month and forward any recommendations to physicians. Psychotropic meeting to be held monthly to assess needs of residents, behavior tracking, and monitor individual psychotropic meds &amp; reason for use.</p> <p>2<sup>nd</sup> consultant pharmacist will review pharmacist's monthly psychotropic evaluations and recommendations each month for at least 90 days.</p> <p>DON or Interim DON will audit 5 residents weekly for a period of at least 12 weeks starting the week of 4/20 to ensure black box warnings are included in any consents if necessary, ensure medication regimens have been reviewed by pharmacist, review completeness of behavior tracking documentation for residents on anti-psychotic medications, and proper indications for psychotropic medications. Any issues will be reported to the QA committee.</p> <p>Facility policy on use of psychotropic medications will be reviewed approved by Medical Director.</p> <p><b>Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure deficiency has been corrected and will not recur:</b></p>	

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

PRINTED: 03/31/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135007</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R-C</b> <b>03/19/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>BINGHAM MEMORIAL SKILLED NURSING &amp; REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>98 POPLAR STREET</b> <b>BLACKFOOT, ID 83221</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 329}	<p>Continued From page 7</p> <p>begin the same pattern of behaviors...Concern would be if any of the combinations of the medications are used with the hydrocodone, and certainly the patient is not very alert...the chanting verbalizations were just her way of expressing or being able to say something, anything, just an expression...if the goal is to have her reduce the amount of talking she does, possibly a shifting of some of the medications might be something that can be done..."</p> <p>On 2/18/14 at 1:50 PM, a physician's progress note for the resident documented, "...Multisensory dementia...We will continue Seroquel as this is more predictable in the geriatric population. I feel her chanting is due to her [hard of hearing] and blindness. Any treatment will most likely be treating the staff and not [Resident #1]."</p> <p>Resident #1's "Active Therapies" (Physician's Recapitulation Orders) for March 2014 documented an order for Seroquel 50 mg twice daily for a diagnosis of dementia with hallucinations.</p> <p>On 3/5/14, a "Pharmacist Consultation Report for Physician Review" form documented, "Federal Tag #331...Residents must, unless clinically contraindicated, have gradual dose reductions of anti-psychotics..." The, "Findings and Assessment" area of the form documented, "...According to HCFA [Health Care and Finance Administration] guidelines, neuroleptic medications used for dementia/behavior-related symptom control must have a gradual dose reduction attempt at least 2 times in 1 year and be unsuccessful before one can conclude that a gradual dose reduction is 'clinically contraindicated'... The "Recommendations" area</p>	{F 329}	<p>The QA committee will review any issues uncovered by weekly audits and after the initial 12 weeks make a determination related to changing the frequency of those audits. Additionally, QA committee will review facility progress on psychotropic drugs at least quarterly on an on-going basis to aid in monitoring compliance.</p>	5/7/14

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

PRINTED: 03/31/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135007</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  R-C <b>03/19/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>BINGHAM MEMORIAL SKILLED NURSING &amp; REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>98 POPLAR STREET BLACKFOOT, ID 83221</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 329}	<p>Continued From page 8 of the form documented, "Please decrease Seroquel to 50 mg [at bedtime] for dementia with hallucinations and agitated features..." [NOTE: HCFA became CMS in 2001. While the pharmacist's recommendations were consistent with HCFA guidance at the time of its existence, they were not consistent with current CMS requirements.]</p> <p>Beginning 1/18/14, and continuing through 3/15/14, there were 14 documents entitled, "Skilled Daily Nurse's Notes" in the resident's record. Each of these forms had an area to mark boxes for the occurrence of hallucinations, illusions, or delusions. Of the 14 forms, 13 of them were blank in this area.</p> <p>"Target Behavioral Symptoms" in the resident's record documented the following behaviors per shift for the use of Seroquel [NOTE: Since the facility was structured with 12 hour shifts, values were only charted with day and night shifts]: *February 2014 -"Hallucinations." Day shift: 18 zeroes, 10 blanks. Night shift: 28 zeroes -"Delusions." Day shift: 18 zeroes, 10 blanks. Night shift: 27 zeroes, 1 blank. -"Chanting." Day shift: 7 threes, 1 four, 1 two, 8 zeroes, and 11 blanks. Night shift: 10 "C's" for "continuous," 11 zeroes, 3 twos, and 4 ones. *March 2014 (through March 18): -"Hallucinations." Day shift: 8 ones, 6 zeroes, 4 blanks. Night shift: 17 zeroes, 1 one. -"Delusions." Day shift: 8 ones, 1 two, 4 blanks. Night shift: 15 zeroes, 3 ones. -"Chanting." Day shift: 3 ones, 3 twos, 1 three, 2 fours, 3 zeroes, 6 blanks. Night shift: 4 ones, 6 "C's", 2 threes, 6 zeroes.</p>	{F 329}		

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

PRINTED: 03/31/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  R-C 03/19/2014
NAME OF PROVIDER OR SUPPLIER  BINGHAM MEMORIAL SKILLED NURSING & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 98 POPLAR STREET BLACKFOOT, ID 83221		
(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 329}	<p>Continued From page 9</p> <p>On 3/19/14 at 1:30 PM, the Administrator, Interim Director of Nursing, Charge Nurse, and LSW were asked about the Seroquel use for Resident #1. The LSW stated she had only recently been hired at the facility, worked only part time, and had not yet had an opportunity to familiarize herself with the histories of all of the residents yet. The LSW stated she was aware Seroquel was indicated for a person with hallucinations, bur for this resident its use was directed at agitation. The Charge Nurse stated the facility perceived the resident's chanting to be a sign of hallucinations because the resident frequently talked about a baby. The facility was unable to describe how talking about a baby was harmful to the resident, but when they had given her a baby doll to hold, it had irritated the resident and she threw it down. The Charge Nurse further stated the facility had discovered that administering pain medications with increased chanting was helpful in reducing the resident's chanting, and at one point the resident had increased chanting related to a bladder infection. The facility staff indicated they thought they were compliant with the requirements based on the pharmacist's recommendations and physician's orders. The facility staff were unable to explain the physician's progress note stating the resident was medicated for staff benefit rather than her own, nor the psychologist's progress note regarding how the medication reduced the resident's ability to express herself.</p> <p>On 3/19/14 at 1:30 PM, the facility provided a copy of a "Behavior/ Psychotropic Drug Monitoring &amp; Reduction" policy. However, the policy was dated as "effective 8/23/10, expires 8/23/13." The facility was asked for an updated version of the policy. The facility did fax an</p>	{F 329}			

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

PRINTED: 03/31/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135007</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R-C</b> <b>03/19/2014</b>	
NAME OF PROVIDER OR SUPPLIER  <b>BINGHAM MEMORIAL SKILLED NURSING &amp; REHABILITATION</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>98 POPLAR STREET</b> <b>BLACKFOOT, ID 83221</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 329}	<p>Continued From page 10</p> <p>updated version on the policy to BFS on 3/21/14, with an implementation date of 3/21/14. The facility offered no policy between the dates of 8/23/13, when the old policy expired, and 3/21/14, when the new policy was implemented.</p> <p>2. Resident #3 was admitted to the facility on 5/31/13. The resident had multiple diagnoses which included dementia, depression, and anxiety.</p> <p>Resident #3's most recent quarterly MDS assessment, dated 12/24/13, coded: *BIMS of 12, indicating moderately impaired decision making skills; and *No hallucinations, delusions, or other behavioral symptoms.</p> <p>On 1/29/14, an "Interdisciplinary Psychoactive Medication Review" form in the resident's record documented a review of her antipsychotic medications. The form documented, "Patient psychosis has been adequately controlled on Seroquel. However, staff reports bizarre behavior (stealing staff/resident personal belongings). Will delay GDR [gradual dose reduction] until Feb or Mar...NO medication recommendations at this time." On 2/26/14, another of the same form documented the exact same information.</p> <p>Resident #3's most Active Therapies form (Recapitulation Orders) for March 2014 documented orders for Seroquel 400 mg daily at bedtime for a diagnosis of "Mood/Depression," and an order for Geodon 10 mg IM (injection) every 2 hours as needed for the same diagnosis. The initiation date for both of these medications was the same as her admission date. [NOTE: The facility had been cited at F 329 on their most</p>	{F 329}		

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

PRINTED: 03/31/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135007</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R-C</b> <b>03/19/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>BINGHAM MEMORIAL SKILLED NURSING &amp; REHABILITATION</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>98 POPLAR STREET</b> <b>BLACKFOOT, ID 83221</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 329}	<p>Continued From page 11</p> <p>recent recertification survey, and had alleged compliance on 1/10/14. The surveyor reviewed the resident's MAR from the date of alleged compliance to the date of the follow-up survey. The resident had not received Geodon in that time, however the medication was still ordered and available for staff to give to the resident.]</p> <p>The resident's Psychoactive Medication Monthly Flow Record for February and March of 2014 documented target behaviors of delusions, hitting, kicking, and paranoia. While the forms contained several blank spaces where behavioral values should have been documented, the remainder of the spaces documented zero behaviors occurred.</p> <p>Between 1/12/14 and 3/16/14, the resident's record contained 12 "Skilled Daily Nurses Notes" forms, with areas to document hallucinations, delusions, and other behavioral symptoms. These areas on all of these forms were blank.</p> <p>On 3/19/14 at 1:15 PM, the Administrator, LSW, IDON, and Charge Nurse were asked about the anti-psychotic use for Resident #3. They reported:</p> <p>*The facility acknowledged incomplete documentation on the behavior tracking sheets, and that it would be difficult to communicate accurately to the physician with the information available.</p> <p>*The LSW initially thought the indication for the use of anti-psychotic medications was bipolar disorder, but after reviewing the record stated, "It says here non-specified mood disorder."</p> <p>*The facility stated the medication was currently being used for the resident's behavioral history, rather than her current behaviors. Since the LSW and IDON were relatively new to the facility, they</p>	{F 329}		

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

PRINTED: 03/31/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135007</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R-C 03/19/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>BINGHAM MEMORIAL SKILLED NURSING &amp; REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>98 POPLAR STREET BLACKFOOT, ID 83221</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 329}	<p>Continued From page 12</p> <p>stated they were basing their assessment of the resident's medication needs on what had been documented in the past.</p> <p>*The LSW stated the resident's physician had not identified a specific target behavior for the use of Seroquel, as far as she knew.</p> <p>*The staff stated the resident shared a room with her husband, and they had been told the resident became paranoid about her husband cheating on her if the two were apart. Therefore, the two were usually together and the resident did fine.</p> <p>*The IDON, Charge Nurse, and LSW were uncertain why the resident continued to have an order for as needed Geodon. They were unable to state what target behavioral symptom would warrant the use of Geodon. The Charge Nurse stated the pharmacist would usually recommend to the MD a medication be discontinued if not used in 30 days, but only when the current supply ran out. The Charge Nurse was unable to explain why such a recommendation had not been made regarding Resident #1 and the availability of Geodon. The Charge Nurse stated the facility nursing staff would never make a recommendation to the MD to discontinue a medication, even if it was an "as needed" medication not being used by the resident.</p> <p>On 3/19/14 at 3:45 PM, the Administrator and IDON were informed of the surveyor's findings. The facility offered no further information.</p>	{F 329}		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001040</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R-C 03/19/2014</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>BINGHAM MEMORIAL SKILLED NURSING &amp; R</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>98 POPLAR STREET BLACKFOOT, ID 83221</b>
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

{C 000}	<p><b>16.03.02 INITIAL COMMENTS</b></p> <p>The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2.</p> <p>The following deficiencies were cited during the follow up for State licensure survey of your facility.</p> <p>The surveyors conducting the survey were: Amy Barkley, RN, BSN Team Coordinator Nina Sanderson, BSW, LSW</p>	{C 000}		
{C 123}	<p><b>02.100.03,c,vii Free from Abuse or Restraints</b></p> <p>vii. Is free from mental and physical abuse, and free from chemical and (except in emergencies) physical restraints except as authorized in writing by a physician for a specified and limited period of time, or when necessary to protect the patient/resident from injury to himself or to others;</p> <p>This Rule is not met as evidenced by: Please refer to F 221 as it refers to the use of restraint.</p>	{C 123}	<p>The following Plan of Correction is submitted by the facility in accordance with the pertinent terms and provisions of 42 CFR Section 488 and/or related state regulations, and is intended to serve as a credible allegation of our intent to correct the practices identified as deficient. The Plan of Correction should not be construed or interpreted as an admission that the deficiencies alleged did, in fact, exist; rather, the facility is filing this document in order to comply with its obligations as a provider participating in the Medicare/Medicaid program(s).</p> <p style="text-align: right;"><b>RECEIVED</b></p> <p style="text-align: right;"><b>APR 30 2014</b></p> <p style="text-align: right;"><b>FACILITY STANDARDS</b></p> <p><b>C123</b></p> <p>Please see POC for F221</p>	<p style="text-align: right;">5/7/14</p>

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

TITLE

(X6) DATE