



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 2540**

June 20, 2013

Craig A. Johnson, Administrator  
Boundary County Nursing Home  
6640 Kaniksu Street  
Bonners Ferry, ID 83805

Provider #: 135004

Dear Mr. Johnson:

On **June 7, 2013**, a Recertification and State Licensure survey was conducted at Boundary County Nursing Home by the Department of Health & Welfare, 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 an isolated deficiency that constitutes actual harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies, and a similar State Form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 3). **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 Form CMS-2567 and State Form, Statement of Deficiencies and Plan of Correction in

the spaces provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **July 3, 2013**. Failure to submit an acceptable PoC by **July 3, 2013**, may result in the imposition of civil monetary penalties by **July 23, 2013**.

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 you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. 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 has 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 5.

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.

Craig A. Johnson, Administrator  
June 20, 2013  
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- The administrator must sign and date the first page of both the federal survey report, Form CMS-2567 and the state licensure survey report, State Form.

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

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS), if your facility has failed to achieve substantial compliance by **July 12, 2013 (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 **July 12, 2013**. A change in the seriousness of the deficiencies on **July 12, 2013**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **July 12, 2013** includes the following:

Denial of payment for new admissions effective **September 7, 2013**. [42 CFR §488.417(a)]

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

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **December 7, 2013**, if substantial compliance is not achieved by that time.

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

If you believe these deficiencies have been corrected, you may contact Loretta Todd, R.N. or Lorene Kayser, L.S.W., Q.M.R.P., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0036; 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. 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.

Craig A. Johnson, Administrator  
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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 **June 7, 2013** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the noncompliance at the time of the revisit, if appropriate.

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

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

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

- BFS Letters (06/30/11)

[2001-10 Long Term Care Informal Dispute Resolution Process](#)  
[2001-10 IDR Request Form](#)

This request must be received by **July 3, 2013**. If your request for informal dispute resolution is received after **July 3, 2013**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact us at (208) 334-6626.

Sincerely,



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

LKK/dmj  
Enclosures

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

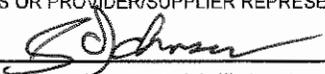
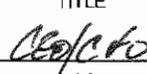
PRINTED: 06/17/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135004</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/07/2013</b>
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NAME OF PROVIDER OR SUPPLIER  <b>BOUNDARY COUNTY NURSING HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>6640 KANIKSU STREET BONNERS FERRY, ID 83805</b>
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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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<p>F 000</p> <p>F 252 SS=B</p>	<p><b>INITIAL COMMENTS</b></p> <p>The following deficiencies were cited during the annual federal recertification and state licensure survey of your facility.</p> <p>The surveyors conducting the survey were: Linda Kelly, RN, team coordinator; and, Bradley Perry, LSW.</p> <p>Survey Definitions: CAA = Care Area Assessment ADL = Activities of Daily Living CNA/NA = Certified Nursing Aide CNO = Chief Nursing Officer LN = Licensed Nurse MDS = Minimum Data Set assessment</p> <p>483.15(h)(1) <b>SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT</b></p> <p>The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, it was determined the facility failed to ensure the environment was maintained in a homelike manner, due to cracks in shower room floor tiles and marred door frames. This affected 1 of 2 shower rooms (#209) and 5 of 21 resident rooms (#204-208). Findings include:</p> <p>1. On 6/3/13 at 4:45 PM, shower room 209 was observed to have a three foot long crack in the</p>	<p>F 000</p> <p>F 252</p>	<p>All dates indicated are for the year 2013. Disclaimer: Plan of correction is being submitted in accordance with specific regulatory requirements. It shall not be construed as an admission of any deficiency cited.</p> <p>Plan of Correction Definitions: EMR = Electronic Medical Record EMAR = Electronic Medication Record DOWNTIME - Meditech electronic system "down" or not available. Documentation on paper required. CIO = Chief Information Officer CEO = Chief Executive Officer CNO = Chief Nursing Officer</p> <p style="text-align: center;"><b>RECEIVED</b> <b>JUL 03 2013</b> <b>DIV OF LIC &amp; CERT</b></p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE 	(X6) DATE <b>7/2/2013</b>
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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 252	Continued From page 1 floor tiles just beyond the entrance threshold. The crack had at least 10 other secondary cracks off of the main crack. The cracks ranged from one sixteenth of an inch to one fourth of an inch wide.  On 6/6/13 at 9:45 AM, during the environmental tour with the Plant Operations Manager, the crack was pointed out to her and she said it is due to the weight of the mechanical lifts bouncing over the threshold and causing damage. At first she said she was unsure what to do about the situation, but then she stated, "I do know what to do about it."  2. On 6/4/13 at 9:10 AM resident rooms 204-208 and shower room 209 were observed to have marred, paint chipped, metal door frames at the entrance to the rooms. The frames were chipped from the floor to approximately one foot off of the floor  On 6/6/13 at 9:45 AM, during the environmental tour with the Plant Operations Manager the door frames were pointed out to her and she stated, "It's from the Hoyer's (mechanical lifts), it's pretty common."  On 6/6/13 at 3:45 PM, the Administrator and the CNO were informed of the issue. No further information was provided.	F 252	F252 Cracked tile has been corrected by adding a stronger material to expand the threshold that will withstand the pressure of the equipment. This was corrected on 6/13/13. Maintenance department will monitor the room for future tile cracks on a weekly basis for four weeks, then monthly for 11 additional months. Monitoring will start on 6/24/13 and continue until 6/24/14.  Chipped paint on door frames has been corrected by maintenance staff by painting the marred areas. This was corrected on 6/13/13. Education materials will be posted for staff reading, in efforts of prevention against equipment damage by 7/31/13. Maintenance department will monitor and correct any paint chips on all extended care door frames on a quarterly basis, touching up damaged areas as necessary, beginning 6/13/13 and continue until 6/13/14, with the process implemented into a regular continuing procedure. Responsible Party: Plant Operations Manager	07/12/13	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.	F 280			

*CG/Chun* CEO/CFO 7/2/13

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F 280	Continued From page 2  A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.  This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility failed to revise care plans for 1 of 9 sampled residents (# 3). The care plan did not reflect revisions for the resident's toileting needs. This had the potential to result in harm if the resident did not receive appropriate care due to lack of direction in the care plan. Findings included:  Resident #3 was admitted on 1/13/09 with multiple diagnoses including chronic pain, deconditioning, and debility.  Resident #3's 5/2/13 Quarterly MDS assessments documented the resident was on a bowel toileting program.  Resident #3's current Elimination Care Plan (CP) dated 3/2/09 did not include an approach or	F 280	Corrective Action: Resident #3 Care plan updated to reflect resident's toileting needs and individualized interventions. Identification of Other Residents: All MDS assessments will be audited for participation in a toileting program (H0300,H0500) . All resident care plans will include the problem "Alteration in Patterns of Elimination" and individualized interventions. Audit Start Date: 06/10/2013 Responsible Party: CNO Systemic Changes: Any resident MDS assessment documenting yes to H0300 and/or H0500 will trigger the Problem: Alteration in Patterns of Elimination and individualized interventions including prompts, frequency etc. will be documented and implemented. Quality Improvement Monitoring: Each MDS assessment completed by the MDS coordinator will be audited to ensure that all triggers are accurately reflected in the residents care plan. Audit Start Date: 06/10/2013 Monitoring Frequency: Weekly x 1mo. then monthly per MDS Schedule. Responsible Party: CNO	07/12/13

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F 280	Continued From page 3 intervention for when to toilet the resident.  On 6/6/13 at 8:55 AM, the MDS Coordinator was interviewed regarding the resident's toileting program. She said the resident was on a scheduled toileting program for bowel elimination.  On 6/6/13 at 9:20 AM, the CNO was interviewed regarding the CP toileting frequency and she stated, "It should be in the care plan, but it's not."  On 6/6/13 at 3:45 PM, the Administrator and CNO were informed of the issue. No further documentation was provided by the facility.	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS  The services provided or arranged by the facility must meet professional standards of quality.  This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure 2 of 6 licensed nurses (LNs) did not pre-initial medications as administered before they actually administered the medications. This affected 3 of 15 residents (#s 1, 8, and 11) during medication pass observations. This failure created the potential for unrelieved pain if the fentanyl patches (long acting pain medication) for Resident #s 1, 8, and 11, and Ibuprofen for Resident #1, had not been administered. Findings included:  Note: Informational Letter #97-3, dated April 16, 1997: The Medication Distribution Technique	F 281	Corrective Action: Resident #1,8,11 Medication to be administered PRIOR to initialing the "downtime" (paper MAR) when EMAR (electronic Medication Record is unavailable. Identification of Other Residents: Medication to be administered PRIOR to initialing the "downtime" MAR when EMAR is unavailable. Systemic Changes: Mandatory Licensed staff mtg. to review Appropriate workflow when administering Medications. Meds are to be administered prior to filing electronically or intialling the "downtime" MAR. Audit Start Date: 07/02/13 Responsible Party: CNO Quality Improvement Monitoring: Medication Pass Audits to be completed weekly x 4, then Q 2 weeks x 1	07/12/13

*[Handwritten Signature]* CEO/CRO 7/2/13

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F 281	<p>Continued From page 4</p> <p>Clarification To Informational Letter, 96-14, from the Bureau of Facility Standards, stated, "The issue arose when the Board of Nursing received information that long term care facility staff were signing medications as given at the time of the medication preparation, not after the resident actually received the medication. ...the Board's expectation, and the accepted standard of practice, is that licensed nurses document those things they have done, not what they intend to do."</p> <p>1. On 6/4/13 at 3:15 p.m., LN #1 was observed as she removed Resident #8's fentanyl 12 microgram (mcg) patch from the med (medication) cart, prepared it for administration, and initialed the medication on the resident's MAR. After that, the LN went to the resident's room and administered the fentanyl patch to the resident's right anterior chest.</p> <p>2. On 6/6/13 at 3:15 p.m., LN #2 was observed as he removed Resident #1's fentanyl 50 mcg patch from the med cart, prepared it for administration, then initialed the medication on the resident's MAR. After that, the LN went to the resident's room and administered the fentanyl patch to the resident's right anterior chest. The resident asked for something for a headache at that time. The LN told the resident he would check what was ordered and be back shortly.</p> <p>At 3:30 p.m., LN #2 was observed as he poured the PRN (as needed) medication, Ibuprofen 600 milligram, 1 tablet, then initialed the medication on Resident #1's MAR. After that, the LN administered the Ibuprofen to the resident.</p>	F 281	<p>then monthly x 2.</p> <p>Responsible Party: CNO/designee</p>		

*[Handwritten Signature]* 06/07/13 7/2/13

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F 281	Continued From page 5 Immediately after the Ibuprofen administration, when asked about pre-initialing Resident #1's fentanyl patch and Ibuprofen, LN #2 acknowledged he had done that. He stated, "Oh, sorry." When informed of the board of nursing's expectation that licensed nurses document those things they have done, not what they intend to do in an effort to prevent/reduce medication errors, the LN stated, "That makes sense."  3. On 6/6/13 at 3:20 p.m., LN #2 was observed as he removed 2 Duragesic (brand name for fentanyl) 12 mcg patches from the med cart for Resident #11, prepared the patches for administration, then initialed the medication on the resident's MAR. The LN took the patches down to the resident's room. However, because the resident was on the toilet, the LN said he would administer the fentanyl later. The LN returned to the med cart with the fentanyl patches in hand.  Immediately afterward, when asked, LN #2 acknowledged he had pre-initialed Resident #11's fentanyl medication. The LN stated, "Oh yes, the dot system. Sorry!"  The LN administered the fentanyl patches to the resident about 20 minutes later.  On 6/6/13 at about 3:50 p.m., the Administrator and CNO were informed of the issue. No other information or documentation was received from the facility.	F 281			
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES  Based on the comprehensive assessment of a	F 314			

*[Handwritten Signature]* *[Handwritten Initials]* 7/2/13

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F 314	<p>Continued From page 6</p> <p>resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure residents who entered the facility without pressure ulcers did not develop pressure ulcers. This was true for 2 of 2 sample residents (#1 and #2) reviewed for pressure ulcers. Resident #1 was harmed when unstageable pressure ulcers developed on the resident's left buttock and left heel. Resident #2 was harmed when a stage 1 left heel pressure ulcer was not initially assessed or monitored and progressed to unstageable. Findings included:</p> <p>1. Resident #1 was admitted to the facility on 5/7/13 with multiple diagnoses including dementia; diabetes mellitus, type 2; gout, peripheral neuropathy; recent urinary tract infection and urinary incontinence.</p> <p>The resident's admission MDS assessment, dated 5/19/13, coded, in part: * Impaired cognition with a BIMS score of 8; * No assistance for bed mobility; * Limited assistance by 1 person for transfers and dressing; * Functional limitation in range of motion in 1</p>	F 314	<p>Corrective Action: Resident #1,2 Braden Skin Risk Scale completed. Wound/Drain Assessments completed. Identification of Other Residents: Audit of Braden Skin Risk Scale for completion of assessment and Risk level to be completed on all residents. Audit start Date: 7/02/13 Responsible Party: CNO Systemic Changes:</p> <ul style="list-style-type: none"> <li>-On admission: All residents will be assessed for level of risk for skin breakdown utilizing the Braden Risk Assessment Scale. All residents with a history of pressure wounds will have a photograph taken of the area(s) and will be referred to the Wound Care Committee for further assessment and preventive interventions.</li> <li>-All residents scoring moderate to high risk will be reviewed weekly for appropriate preventive interventions.</li> <li>-All residents with wounds will be turned and/or repositioned per schedule determined by the Wound Care Committee and will be documented in the "Activity: Turn/Reposition Patient" intervention in the EMR.</li> <li>-All wounds will be assessed and documented in the "Advanced Wound Assessment" daily.</li> </ul>	07/12/13

*S. Johnson* CEO/CFO 7/2/13

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135004</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/07/2013</b>
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F 314	<p>Continued From page 7</p> <p>upper extremity and both lower extremities; * Wheelchair (w/c) and walker use; * Frequent urinary incontinence; * One unstageable pressure ulcer (PU) in the past 7 days, due to slough or eschar; * One unstageable PU in the past 7 days, due to suspected deep tissue injury (sDTI); * Pressure ulcer care; and, * Application of dressing to feet (with or without topical medication).</p> <p>Resident #1's Pressure Ulcer CAA Analysis of Findings, dated 5/21/13, documented, "...admitted with a red coccyx which has resolved. Flakey [sic] skin to (L) [left] heel found 5-16 and heel protectors placed while in bed. ... ..pressure area was brought to the daughters [sic] attention, she stated "Ya, she's had those before..."</p> <p>The resident's Plan of Care identified the problem, "...at risk for skin pressure due to: ... Current breakdown on coccyx... Restless leg per daughter[,] reports Hx [history] of heel wounds," on 5/19/13. The goal was, "Current pressure area to coccyx will heal and no further issues will develop." Interventions included: * "Apply cream and dressing as needed to coccyx as ordered." * "5/16 - Blue Boots on in bed RSDT [resident] removes frequently [with] restless leg. - Weekly SAR [Skin At Risk]/Wound meeting. - Weekly photo [with] wound documentation. - RSDT to wear non-skid socks instead of canvas shoes." * "Assess for skin breakdown during baths and personal cares..." * "Licensed staff skin assessment weekly."</p> <p>On 6/5/13 the Charge Nurse provided</p>	F 314	<p>(Cont. from previous page)</p> <p>-All photograph documentation will be accurately completed and include all descriptors i.e. measurements, drainage etc. -All residents will be assessed weekly for signs/symptoms of skin breakdown. ***If EMR is unavailable, documentation will be completed utilizing downtime flow sheet and progress notes and scanned to the EMR . Responsible Party:Licensed Nursing Quality Improvement Monitoring: Audit of all Wound Care Committee documentation for accuracy and completion . Frequency: Weekly x 4 weeks,then monthly x 3 months Responsible Party: CNO</p>	07/12/13
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*S. Johnson*      CCO/CO      7/2/13

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F 314	<p>Continued From page 8</p> <p>Photograph Documentation (PD) of Resident #1's left buttock and left heel PUs. The PD included areas in which to document: date; type: wound, laceration, bruise/contusion, burn, or other; size in centimeters [cm]; depth; presence/absence of drainage; comments; nurse's signature and photographer's signature; a front and a back body diagram with instructions to "Mark Photographed Location;" and, a photograph.</p> <p>The PD regarding the resident's left buttock PU documented: * 5/7/13 photo taken 5/8/13" - a Stage II intact "drying" blister 0.25 by 0.5 cm adjacent and above a 2.5 x 2 cm non blanching purple area. Both of these areas were inside a 12 x 7 cm red blanching area. Areas to document depth and drainage were blank. "Comments: Will treat [with] Calazime [with] attend [changes] Gel cushion in w/c CNA's [sic] to turn [and] reposition Q [every] 2 [hours], Family had been treating at home." The posterior body diagram contained 2 Xs in the left buttock area and the photograph (photo) showed the aforementioned 3 areas as described above. * 5/15/13 - "Type: Wound and Size... See back." A MediRule wound measurement tool, documented a superior wound as 4 cm x 2 cm and an inferior wound as 4.5 cm x 3.2 cm. Areas to document depth and drainage were blank. The posterior body diagram contained an X in the left buttock area. The photo revealed a superior and an inferior wound at the left inner buttock. The superior wound bed appeared white with dry flakes at the left top edge. The inferior wound bed appeared red with a white patch at the right side of the wound and dry flaky skin around the wound. * 5/21/13 - "Type: Wound [and] Other:</p>	F 314			

*S. Johnson* 050/060 7/2/13

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F 314	<p>Continued From page 9</p> <p>excoriation[;] Size... 1 cm x 2 cm[;] Depth: superficial." The space to document drainage was blank. "Comments: epithelial tissue noted." The posterior body diagram contained a circle at the left lower, inner buttock area. However, the photo showed 2 circular areas, a small wound above a larger wound. Both wounds appeared dry and white (possibly Calazime). Note: The 5/21/13 PD did not identify to which wound the measurements correlated.</p> <p>The PD regarding the resident's left heel PU included: * 5/16/13 - "Type: Bruise/Contusion Other: (L) heel." Areas to document depth, drainage, and comments were blank. The posterior body diagram contained a circle at the left heel. The photo documented a large black wound with what appeared to be yellow flaky areas in and around the wound. * 5/21/13 - "Type: Other: Drying pressure ulcer[;] Size...[;] 2 cm x 3.5 cm[;] Depth: unknown[;] ...Drainage: [none][;] Comments: Borders beginning to lift." The posterior body diagram contained an arrow drawn to the left heel. The photo showed an oblong black area with dry flaking tissue at the top and bottom of the blackened area and a small pink area below the blackened area. * 5/27/13 - "Type: Wound[;] Size...: 4 cm diameter." Areas to document depth and drainage were blank. "Comments: RSDT not cooperative [with] blue boots, legs restless in bed. RSDT to wear non-skid socks vs [versus] shoes." The posterior body diagram contained an arrow to the left heel. The photo showed a large, slightly oblong wound with a red base near the center and bottom of the wound with gray/black patches</p>	F 314			

*SD*

*ceo/cfo*

*7/2/13*

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F 314	<p>Continued From page 10 around and on the right side of the red tissue.</p> <p>On 6/5/13 at 10:15 a.m., the Charge Nurse (CN) was asked about Resident #1's left heel and left buttock PUs. The CN provided a 5/7/13 7:50 p.m. emergency department visit note which documented, in part, "Skin/Healing History...pressure area's [sic] on bilateral feet and buttocks, not open." The CN stated the resident was admitted with a calloused area on the right heel, nothing on the left heel, and 2 stage II PU areas on the left buttock. The CN added, "I have no documentation prior to June. All I have is what's here because all those daily checks would be in [the system identified as the facility's software program provider of their electronic medical record (EMR)]."</p> <p>Note: Refer to F514 regarding the accuracy, completeness, accessibility, and systematic organization of residents' clinical records related to the EMR.</p> <p>On 6/6/13 at 9:15 a.m., the CN was asked to provide documentation of Resident #1's admission nursing assessment with any identified areas of skin breakdown, the admission and any subsequent PU risk assessments, and weekly skin checks by a LN. The CN stated, "We probably are not going to get anything out of [the EMR system]. At this point we have no access, no way to get it."</p> <p>On 6/6/13 at 11:30 a.m., with Resident #1's agreement, LN #3 showed the surveyor the resident's heels and buttock. A large oblong PU was on the back of the left heel. The top half of the left heel PU was covered in dry, cracking black eschar that was lifting at the edges. Pink</p>	F 314		
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*S. J. Chan*      *CEC/CFO*      *7/2/13*

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F 314	<p>Continued From page 11</p> <p>granular tissue was in the lower half of the left heel PU. The right heel was intact without any reddened or boggy areas. The buttocks were intact with darkened pigmentation noted at the inner aspect on the left and the right. The darkened skin on the left was about 3 inches wide. It covered the area just below the sacral level to just below the rectal area. The darkened skin on the right was about 2 inches wide and much smaller than the left side.</p> <p>The facility's documentation about Resident #1's PUs was inconsistent. The 5/19/13 MDS documented 2 unstageable PUs were present during the previous 7 days while the 5/21/13 PU CAA noted only redness at the coccyx and flaky skin on the left heel. No other PU area concerns were noted in the CAA. Also, the PD revealed that eschar (unstageable by definition) was present on the left heel PU.</p> <p>The resident developed an unstageable left heel pressure ulcer and, per facility documentation, an unstageable left buttock PU when the facility failed to assess the resident's skin and PU risk upon admission to the facility on 5/7/13 and did not monitor the resident's buttock for 7 days and the left heel for 8 days after admission.</p> <p>On 6/5/13 at 4:15 p.m. and 6/6/13 at 3:45 p.m., the Administrator and the CNO were informed of the harm issue regarding the PUs to Resident #1's left buttock and left heel. However, the facility did not provide any other information or documentation about the PUs.</p> <p>2. Resident #2 was admitted to the facility on 2/8/02, and readmitted on 5/8/13 status post</p>	F 314			

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F 314	<p>Continued From page 12</p> <p>dehydration with multiple diagnoses including advanced age, dementia, resolved altered level of consciousness and urinary tract infection.</p> <p>The resident's 5/14/13 admission MDS assessment coded, in part:</p> <ul style="list-style-type: none"> <li>* Severe cognitive impairment, with a BIMS score of 3;</li> <li>* Extensive assistance of 2 people for bed mobility and transfers;</li> <li>* Total assistance of 1 person for dressing, hygiene, and bathing;</li> <li>* At risk for pressure ulcers (PU);</li> <li>* No unhealed PU, venous/arterial ulcers, or other skin problems.</li> </ul> <p>Resident #2's June 2013 Plan of Care identified the problem, "...potential for impaired skin integrity..." Interventions included, "Skin assessment weekly and as needed [by LN]. Monitor skin on bath day and during cares for s/sx [signs and/or symptoms] of skin breakdown... [by NA]. Assist/cue to turn every 2 hours and as needed [by NA]. Check left heel on even nights [by LN]." In handwriting and dated 5/15/13 was, "Blue boot on at all times [except with] transfers. Photo[graph] of heel wound [every] week. Weekly SAR [skin at risk] meeting."</p> <p>On 6/4/13 at 9:50 a.m., 10:30 a.m., and 12:35 p.m., Resident #2 was observed with a dark blue Prevalon boot on the left foot.</p> <p>On 6/5/13 at 11:00 a.m., the Charge Nurse (CN) was asked about Resident #2's left heel. The CN confirmed the resident had a left heel PU and stated, "The first Nurses' Note on the pressure ulcer would have been in [the EMR] and that's</p>	F 314			

*[Handwritten Signature]* CEO/CFO 7/2/13

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F 314	<p>Continued From page 13</p> <p>lost. The first available documentation is 5/12/13." Note: Refer to F514 regarding the accuracy, completeness, accessibility, and systematic organization of residents' clinical records related to the EMR.</p> <p>On 6/5/13 at 12:15 p.m., the CN stated Resident #2 was admitted with an intact left heel PU that was caused by edema after IV (intravenous) fluids during an acute care stay. The CN provided a 5/7/13 acute care physician note and pointed out the following documentation, "Abnormal: Edema (trace left LE [lower extremity] edema." This 5/7/13 note also documented, "Integumentary Normal: No Ulcers." The CN added, "We don't have access to our Nurses' Notes." She also stated, "I might be able to go back in the old chart and care plan to show we were checking her heel every other evening." At that time, the CN provided Photograph Documentation (PD) and Physician/Staff Communications (P/SC) regarding Resident #2's left heel PU.</p> <p>The PD included areas in which to document: date; type: wound, laceration, bruise/contusion, burn, or other; size in centimeters [cm]; depth; presence/absence of drainage; comments; nurse's signature and photographer's signature; a front and a back body diagram with instructions to "Mark Photographed Location;" and, a photograph.</p> <p>The PD and P/SC documentation included: * 5/12/13 PD - "Type: Other: Non blanchable red area on left heel[;] Size...: 1.5 fluid filled 2.5 whole wound[;] Depth: unknown[;] ...Drainage: [no] drainage[;] Comments: protective boot applied."</p>	F 314		
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*[Handwritten Signature]*      *CE/060*      *7/2/13*

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F 314	Continued From page 14 The posterior body diagram contained an X at the left heel and the photo showed a large bright red, intact wound. * 5/12/13 P/SC - "...increased leg edema...also has a pressure blister [with] fluid underneath on her heel." The physician ordered an increase in Lasix (diuretic). * 5/15/13 - "Type: Bruise/Contusion Other: (L) heel." Areas to document the size, depth, drainage, and comments were blank. The posterior body diagram contained a circle at the left heel and the photo showed a large black wound with redness on one side of the eschar and dry peeling skin on the opposite side of the eschar. The physician wrote, "I will come [and] see her." * 5/15/13 P/SC - "...lg [large] blood blister looking area to heel..." * 5/21/13 PD - "Type: Other: pressure ulcer[;] Size...: 3.5 cm [by] 2.5 cm[;] Depth: unknown[;] ...Drainage: Fluid filled blister." The posterior body diagram contained an arrow drawn to the left heel and the photo showed a large intact black wound. * 5/27/13 PD - "Type: Other [blank otherwise][;] Size...: 2 cm [by] 3 cm (irregular)[;] Comments: RSDT's [Resident's] heel cont[inue] to dry edema [down], [increased oral] intake [times] last 2 days." The posterior body diagram contained a circle at the left heel and the photo showed an intact dry black wound. * 6/3/13 PD - "Type: Other [blank otherwise][;] Size...: 2 cm [by] 3 cm[;] Depth: N/A [not applicable][;] ...Drainage: None. Comments: Area flat. Drying. P.O. [oral] intake varied. No edema." The posterior body diagram contained an arrow drawn to a circle on the left heel and, "Soft boot on foot at all times except during transfer if with	F 314			

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F 314	Continued From page 15 sit-to-stand [type of mechanical lift]. Arjo [type of lift used for total transfers] used mostly."  On 6/5/13 at 1:15 p.m., the CN provided an April 2013 Plan of Care and stated that heel checks every other evening were in place. She stated, however, "I just can't show the documentation to that because it's in [the EMR system.]" The CN was asked to provide the initial nursing assessment, any identified skin issues, and the initial and any subsequent PU risk assessments when Resident #1 was readmitted to the facility on 5/8/13. The CN indicated that information also was not available.  Resident #2 developed an unstageable left heel pressure ulcer when the facility failed to assess the resident's skin and PU risk upon readmission the facility on 5/8/13 and did not monitor the resident's left heel for at least 4 days after readmission on 5/8/13.  On 6/5/13 at 4:15 p.m. and 6/6/13 at 3:45 p.m., the Administrator and the CNO were informed of the harm issue regarding the PUs to Resident #2's left heel. However, the facility did not provide any other information or documentation about the PU.	F 314			
F 514 SS=F	483.75(I)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE  The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.	F 514	Corrective Action: Residents 1 - 10 Available clinical documentation will be retrieved and re-incorporated as components of the current medical record. All other data that is available within the back-ups and data repository(2nd back up) is being collected and re-incorporated into the EMR.	07/12/13	

*Signature* CEO/CFO 7/2/13

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135004</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/07/2013</b>
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NAME OF PROVIDER OR SUPPLIER  <b>BOUNDARY COUNTY NURSING HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>6640 KANIKSU STREET BONNERS FERRY, ID 83805</b>
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F 514	<p>Continued From page 16</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure clinical records were complete, accurated, readily accessible, and systematically organized. This was true for 10 of 10 sample residents (#1-10) and potentially all other residents in the facility. This failure placed residents at risk for unnecessary, and potentially inappropriate, care related to medical decisions based on incomplete or inaccurate information. Findings included:</p> <p>Note: On 6/3/13 at 3:45 p.m., during the entrance interview with the Administrator and the CNO, the Administrator stated the facility had a "catastrophic crash" of the EMR (electronic medical record) system on 5/29/13. The Administrator added, "We are still finding out what is and is not retrievable." The DON stated the facility reverted to paper documentation as of 5/30/13.</p> <p>On 6/3/13 at 5:00 p.m., the Administrator provided an update by [the facility's documentation software program provider]. The update, dated 6/3/13, noted, in part, "* This was a catastrophic server failure which has ramifications beyond the actual downtime. The recovery process has required that for many of</p>	F 514	<p>(cont. from previous page)</p> <p>Responsible Party: Medical Records Director</p> <p>Quality Improvement Monitoring: A location-specific backup report (including identified residents) will be generated and kept on file,detailing success/failure of data archive and restoration activities. Frequency: Weekly, in perpetuity</p> <p>Responsible Party: outsourcing company (DELL) will monitor daily the backups,the data repository and the stability of the electronic system</p> <p>Identification of Other Residents: A gap analysis was conducted to determine those affected with no additional corrupt records discovered.</p> <p>Quality Improvement Monitoring: A location-specific risk assessment report will be generated and kept on file. Any risks identified will be the subject of separate and distinct remedy plans, also to be kept on file. Monitoring Frequency: Weekly, in perpetuity. Responsible Party: Medical Records Director</p>	
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*S. Johnson CEO/CFO 7/2/13*

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

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F 514	<p>Continued From page 17</p> <p>our clinical applications we revert back to the data that lived in the system as of October 10, 2012. * For patients seen between October 10, 2012 and May 29, 2012 some information in the EMR will not be recovered at all and other information will take time to be restored.." This update further noted, "Patient Care and Notes Tabs: New info[rmation] is being documented by staff, any information from prior to coming back online 5/31 will NOT be recovered to the EMR."</p> <p>On 6/4/13 at 10:15 a.m., the Administrator said that documentation regarding pressure ulcers and specific pain assessments were "lost."</p> <p>On 6/5/13 at 9:30 a.m., the Administrator stated that monthly pharmacy reviews were "lost" and MARs could be printed "back to April" for individual residents.</p> <p>On 6/7/13 at about 10:30 a.m., during the Exit Conference with the Administrator, CNO, and several other staff, the Administrator expressed doubt that most of the aforementioned clinical documentation could be retrieved.</p> <p>1. Resident #1 was admitted to the facility on 5/7/13 with multiple diagnoses including dementia; diabetes mellitus, type 2; gout, peripheral neuropathy; recent urinary tract infection and urinary incontinence.</p> <p>During the survey week, the facility was unable to provide Resident #1's initial nursing assessment, including identified areas of skin breakdown, a pressure ulcer (PU) risk assessment, or documentation that the resident's left buttock PU and left heel PUs were comprehensively</p>	F 514	<p>(cont. from previous page)</p> <p>System Changes: The current patient database will completely transferred to a more stable up-to-date server and storage destination.</p> <ul style="list-style-type: none"> <li>- A detailed backup and restore plan will be kept and monitored for updates; this plan and any subsequent updates will be provided to this facility and the remedy details will be communicated.</li> <li>- Backups are validated daily to ensure full backups are available and are not corrupt.</li> <li>- Daily reports are provided with any errors reported immediately.</li> </ul> <p>Frequency: Daily, in perpetuity Responsible Party: Chief Information Officer, Kootenai Health</p> <p>Quality Improvement Monitoring: Reports will be reviewed by Kootenai Health Quality Assurance Committee. Any unsatisfactory data contained within the reports will be immediately reported to this facility and remedy details will be addressed between this facility and Kootenai Health Quality Assurance Committee.</p> <ul style="list-style-type: none"> <li>- Location- specific risk assessment report will be generated and kept on file. Any risks identified will be the subject of separate and distinct remedy plans.</li> </ul> <p>Responsible Party: Chief Information Officer Kootenai Health</p>		

*[Handwritten Signature]* 05/07/13 7/2/13

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F 514	<p>Continued From page 18</p> <p>assessed, monitored, and care planned interventions were implemented. Note: Refer to F314, Pressure Ulcers, for details.</p> <p>On 6/6/13 at 3:45 p.m., during the end of day meeting with the Administrator and the CNO, the administrator stated the records may never be recovered.</p> <p>2. Resident #2 was admitted to the facility on 2/8/02, and readmitted on 5/8/13 status post dehydration with multiple diagnoses including advanced age, dementia, resolved altered level of consciousness and urinary tract infection.</p> <p>During the survey week, the facility was unable to provide Resident #2's initial nursing assessment after readmission, including identified areas of skin breakdown, a pressure ulcer (PU) risk assessment, or documentation that the resident's left heel PU was comprehensively assessed, monitored, and care planned interventions were implemented. Note: Refer to F314, Pressure Ulcers, for details.</p> <p>On 6/6/13 at 3:45 p.m., during the end of day meeting with the Administrator and the CNO, the administrator stated the records may never be recovered.</p> <p>3. Resident #4 was admitted to the facility on 1/7/13, with multiple diagnoses including congestive heart failure, hypertension, and depression.</p> <p>Resident #4's social service notes were unavailable for the entire survey due to an EMR failure.</p>	F 514	<p>(cont. from previous page)</p> <p>Responsible Party: Chief Executive Officer NOTE: This in-process work is being completed by our outsourcers, Dell and Meditech. They have provided the plans for the remediation and ongoing monitoring of the server that failed. They are also providing daily status updates and validations of all restores of the prior day's backups. There are multiple other technical systematic changes that are, or will be put in place to ensure this does not happen in the future. There are over 50 staff members engaged and working to ensure the system is stable and fully remediated.</p> <p>In addition, our current outsourcing company, DELL, manages the failed server and was responsible for the server failure and failed backups. A long-term plan and project has been started to evaluate and determine the cost for a change in vendor or in-source of the servers. This is underway and will provide a plan for the full remediation of all failures by Dell to date.</p> <p>All of the residents admitted during this Catastrophic crash, were re-admitted on 6/13/13 in order to establish a complete record. All other data that is available within the backups and data repository(2nd backup) is being collected and re-incorporated into the EMR</p>		

*[Handwritten Signature]* CEO/CFO 7/2/13

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F 514	<p>Continued From page 19</p> <p>On 6/6/13 at 3:45 PM during an end of day conference and interview with the Administrator and CNO, the administrator said the records may never be recovered.</p> <p>4. Resident #5 was admitted to the facility on 6/26/12, with multiple diagnoses including weakness, debility, and dementia.</p> <p>Resident #5's April and May 2013 range of motion tracking sheets and notes were unavailable for the entire survey due to an EMR failure.</p> <p>On 6/6/13 at 3:45 PM during an end of day conference and interview with the Administrator and CNO, the administrator said the records may never be recovered.</p> <p>5. Similar findings were noted for Resident #3, 6, 7, 8, 9, and 10.</p>	F 514			

*G Johnson* CEO/CFO 7/2/13

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001070</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/07/2013</b>
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C 000	16.03.02 INITIAL COMMENTS  The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2. The following deficiencies were cited during the annual state licensure survey of your facility.  The surveyors conducting the survey were: Linda Kelly, RN, team coordinator; and, Bradley Perry, LSW.	C 000	<p><b>RECEIVED</b></p> <p><b>JUL 03 2013</b></p> <p><b>DIV OF LIC &amp; CERT</b></p>	
C 361	02.108,07 HOUSEKEEPING SERVICES AND EQUIPMENT  07. Housekeeping Services and Equipment. Sufficient housekeeping and maintenance personnel and equipment shall be provided to maintain the interior and exterior of the facility in a safe, clean, orderly and attractive manner. This Rule is not met as evidenced by: Refer to F252 regarding cracked floor tiles and marred up door frames.	C 361		REFER TO F-252 FOR PLAN OF CORRECTION
C 782	02.200,03,a,iv Reviewed and Revised  iv. Reviewed and revised as needed to reflect the current needs of patients/residents and current goals to be accomplished; This Rule is not met as evidenced by: Refer to F280 regarding toileting care plan not updated.	C 782		REFER TO F-280 FOR PLAN OF CORRECTION
C 789	02.200,03,b,v Prevention of Decubitus	C 789		REFER TO F-314 FOR PLAN OF CORRECTION

Bureau of Facility Standards



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

TITLE

*ceo/ceo*

(X6) DATE

*7/2/13*

Bureau of Facility Standards

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C 789	Continued From page 1  v. Prevention of decubitus ulcers or deformities or treatment thereof, if needed, including, but not limited to, changing position every two (2) hours when confined to bed or wheelchair and opportunity for exercise to promote circulation; This Rule is not met as evidenced by: Refer to F314 as it related to pressure ulcers.	C 789		
C 797	02.200,03,c Documentation of Nursing Assessments  c. Nursing staff shall document on the patient/resident medical record, any assessments of the patient/resident, any interventions taken, effect of interventions, significant changes and observations and the administration of medications, treatments and any other services provided. Entries shall be made at the time the action occurs and shall be signed by the person making the entry and shall provide the time and date of the occurrence. At a minimum, a monthly summary of the patient's/resident's condition and reactions to care shall be written by a licensed nursing staff person. This Rule is not met as evidenced by: Refer to F281 as it related to professional standards.	C 797	REFER TO F-281 FOR PLAN OF CORRECTION	
C 879	02.203 PATIENT/RESIDENT RECORDS  203. PATIENT/RESIDENT RECORDS. The facility maintains medical records for all patients/residents in	C 879	REFER TO F-514 FOR PLAN OF CORRECTION	

*S Johnson*  
6899 VVZC11  
06/07/13 7/2/13

Bureau of Facility Standards

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C 879	Continued From page 2  accordance with accepted professional standards and practices. This Rule is not met as evidenced by: Refer to F514 as it related to residents' clinical records.	C 879		

*[Signature]* 0099 VVZC11  
CSO/CAO 7/2/13