



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
5232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

CERTIFIED MAIL: 7012 1010 0002 0836 2458

July 30, 2013

Shon L. Shuldberg, Administrator
Ashton Living Center
700 North Second Street, PO Box 838
Ashton, ID 83420

Provider #: 135097

Dear Mr. Shuldberg:

On **July 19, 2013**, a Recertification and State Licensure survey was conducted at Ashton Living Center 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 one that comprises a pattern that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

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

Shon L. Shuldberg, Administrator
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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 **August 12, 2013**. Failure to submit an acceptable PoC by **August 12, 2013**, may result in the imposition of civil monetary penalties by **September 2, 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.

Shon L. Shuldberg, Administrator
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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 **August 16, 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 **August 16, 2013**. A change in the seriousness of the deficiencies on **August 16, 2013**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **August 16, 2013** includes the following:

Denial of payment for new admissions effective **October 19, 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 **January 19, 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.

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.

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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 **July 19, 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:

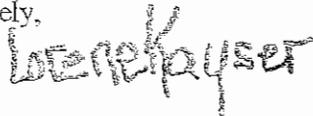
- BFS Letters (06/30/11)

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

This request must be received by **August 12, 2013**. If your request for informal dispute resolution is received after **August 12, 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

AH
"A" FORM

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 135097	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 7/19/2013
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NAME OF PROVIDER OR SUPPLIER ASHTON LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 700 NORTH 2ND STREET ASHTON, ID
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
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F 204	<p>483.12(a)(7) PREPARATION FOR SAFE/ORDERLY TRANSFER/DISCHRG</p> <p>A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to account for a discharged resident's belongings. This affected 1 of 1 (#10) closed records reviewed. Findings included:</p> <p>Resident #10 was admitted to the facility on 12/21/12 with multiple diagnoses including depressive disorder. On 5/5/13 the resident discharged from the facility.</p> <p>Review of the resident's electronic database closed record did not provide evidence of an account of the resident's belongings. The record contained a form titled Inventory of Personal Items. The signature section of the form was not signed to indicate the resident, a family member, or responsible party was given the resident's belongings.</p> <p>The resident's Progress Notes did not contain an entry by facility staff to indicate the resident's belongings were accounted for.</p> <p>On 7/18/13 at 8:24 a.m., the surveyor informed Medical Records the accounting of the resident's belongings was not in the resident's record in the electronic database. Medical Records reviewed the electronic database and was unable to provide evidence the resident's belongings were accounted for at discharge.</p> <p>On 7/18/13 at 9:00 a.m., the surveyor informed the DON the resident's record did not provide evidence of an accounting of the resident's belongings. The DON acknowledged understanding.</p> <p style="text-align: right;">RECEIVED AUG 12 2013 FACILITY STANDARDS</p>
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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

The above isolated deficiencies pose no actual harm to the residents

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

PRINTED: 08/23/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135097	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/19/2013
NAME OF PROVIDER OR SUPPLIER ASHTON LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 700 NORTH 2ND STREET ASHTON, ID 83420	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following deficiencies were cited during the annual Federal recertification survey of your facility. The surveyors conducting the survey were: Karen Marshall, MS, RD, LD Team Coordinator Rebecca Thomas, BSN, RN Amy Jensen RN Survey Definitions: CNA = Certified Nurse Aide DNS/DON = Director Nursing Services/Director of Nursing LN = Licensed Nurse MDS = Minimum Data Set assessment MG = Milligram MAR = Medication Administration Record	F 000	Preparation and/or execution of the plan of correction does not constitute admission of agreement by the provider of the the truth of the facts alleged or conclusions set forth in statement.	
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, record review, and staff interview, it was determined the facility failed to ensure professional standards of quality were maintained. This was true for 1 of 11 sampled residents (#11) when Omeprazole was not administered per the manufacturer's specifications 30-60 minutes before a meal. This failed practice had the potential to cause abdominal discomfort and decreased nutritional intake if the medication was not taken as	F 281		

RECEIVED
SEP - 3 2013
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE 8/8/13

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135097	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/19/2013
NAME OF PROVIDER OR SUPPLIER ASHTON LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 700 NORTH 2ND STREET ASHTON, ID 83420		
(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 281	Continued From page 1 directed. Findings include: CMS (Centers for Medicare and Medicaid Services), in an informational letter, S&C: 13-02 NH dated 11/02/12, the following information was provided related to the use of PPIs. "...For optimal therapeutic benefit, most PPIs should be administered on an empty stomach, ideally 30-60 minutes before meals. The rationale is that in order for the medication to provide the maximum benefit it needs to be present in the system before food activates the acid pumps so that the peak concentration of the PPI will coincide with maximal acid secretion..." The Nursing 2014 Lippincott Drug Handbook, "Omeprazole capsules [delayed-release] should be given at least 1 hour before meals." Resident #17's July 2013, "Physicians Order Report" contained the following order, "Omeprazole capsule, Delayed Release (E.C.); 20 mg; amt 1 capsule; Oral Once A Day; 07:30. [Omeprazole 20 mg delayed release capsule, one by mouth every day at 7:30 a.m.]" Resident #17's bubble packed medication card, provided by the Pharmacy, documented in part the following: - "Omeprazole 20 mg Capsule DR [delayed release]..." - "Take 1 capsule by mouth once daily for reflux." NOTE: The Physician's Order and the bubble packed medication card did not include the manufacturer's specifications for administering the Omeprazole, "at least 30-60 minutes before meals."	F 281	Specific Resident - Resident #17 PPI Omeprazole was given 30-60 minutes before meals following observation by surveyor. Other Residents - All residents have potential to be affected. Administration of Proton Pump Inhibitors policy was reviewed by DNS in charge nurse meeting July 24. These meds are to be given on an empty stomach 30-60 minutes prior to the meal. Systemic Changes - The Pharmacy will be asked to place in the instruction area of each medication card the instructions for appropriate time of administration of the PPI. DNS will place a sign on med cart listing PPIs we use and describing correct administration. Monitor - Starting 8/7/2013 DNS will observe a.m. med passing for one week, then each LN weekly for one month reminding every nurse individually of correct procedure for PPI admin. Findings will be reported to QA committee.	8/13/2013	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135097	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/19/2013
NAME OF PROVIDER OR SUPPLIER ASHTON LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 700 NORTH 2ND STREET ASHTON, ID 83420		
(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 281	Continued From page 2 On 7/18/13 at 8:30 a.m., LN #1 administered the Omeprazole to Resident #17 and then the resident was taken to the dining room for breakfast. At 8:40 a.m. Resident #17 was observed eating her breakfast. The time between the administration of the Omeprazole and when the resident started eating her breakfast was only 10 minutes. Because the Omeprazole was not given 30-60 minutes prior to breakfast, it did not have adequate time to reach, "Optimal therapeutic benefit." On 7/18/13 at 1:30 p.m. the DNS was notified about the medication error. The DNS said it was a recognized standard of practice, that this medication should be given 30-60 minutes prior to eating and the nurses should know that.	F 281			
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility failed to ensure increased supervision was implemented and continued for 1 of 10 (#5) sampled residents. Failure to implement 30 minute checks, as care	F 323			

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135097	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/19/2013
NAME OF PROVIDER OR SUPPLIER ASHTON LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 700 NORTH SECOND STREET ASHTON, ID 83420		
(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 323	<p>Continued From page 3</p> <p>planned, placed the resident at increased risk for falls and injury. Findings included:</p> <p>Resident #5 was admitted to the facility on 12/16/06 with multiple diagnoses to include, anxiety, depression, psychosis, heart failure, hypertension, diabetes mellitus, and Non-Alzheimer's dementia.</p> <p>Resident #5's Annual MDS dated 6/10/13, coded the following: - "Sometimes," has the ability to make herself understood, - "Sometimes," has the ability to understand others, - Has the resident wandered in the last 7 days, "Behavior of this type occurred 4 to 6 days, but less than daily." - Two person extensive assist for transfers, bed mobility, and toileting.</p> <p>Resident #5's Care Plan included the following documentation: * Problem Start Date: 4/16/2013 -Category: Falls -"CNA doing 30 min [minute] checks and going to get [Resident #5] ready for bed. Just as CNA walked into [Resident #5's] room, [Resident #5] was in the process [of] getting out of WC [wheelchair]. Res[ident] fell first on L [left] knee then on R [right] shoulder and then face..." *Approach Start Date: 6/20/13 - "Observe frequently and place in supervised area when out of bed. Q [every] 30 minute checks to know [Resident #5's] location..."</p> <p>Resident #5's, "Progress Notes" taken from 6/16/13 to 7/16/13, documented the following was being done everyday, "Staff cont. q [continue</p>	F 323	<p>Specific Resident - Resident #5 Q30 checks in place. The clipboard to remind staff who is on Q30 was updated to have Resident #5 on the list. Staff was educated of which residents were on Q30 checks</p> <p>Other Residents - Have potential to be affected. Lists were checked for accuracy to make sure all the staff know and the residents that should be on Q30 checks are receiving Q30 checks by all CNA's and Nurses.</p> <p>Systemic Change - Each morning the charge nurse will double check the LN list of Q30 checks with CNA's clipboard to ensure they are both updated with correct residents on both lists. List of residents on Q30 checks will be reviewed every Monday by stand up committee to ensure all residents on Q30 are being check Q30 according to care plan. To ensure supervision and safety of all identified residents needing Q30 checks.</p> <p>Monitor - DNS will audit daily for one week, starting 7/22/2013 then monthly for 6 months LN list of Q30 checks with CNA's list to ensure they both include the same residents, and flow sheets are in place.</p>	8/13/2013	

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135097	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/19/2013
NAME OF PROVIDER OR SUPPLIER ASHTON LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 700 NORTH 2ND STREET ASHTON, ID 83420		
(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 323	<p>Continued From page 4 every] 30 min checks..." or "Res continues on q 30 min checks for safety..."</p> <p>On 7/17/13 at 1:30 p.m., CNA #2 was interviewed and asked where the facility keeps their 30 minute check flow sheets and how do the CNAs know who is on 30 minute checks. CNA #2 showed the surveyor a clipboard which contained a list of the residents currently on 30 minute checks and each resident's flow sheet. Resident #5 was not on the list of residents requiring 30 minute checks and she did not have a flow sheet. The surveyor asked CNA #2 if Resident #5 was on 30 minute checks. CNA #2 said they were not doing 30 minute checks on Resident #5. The CNA said she remembered Resident #5 had been on 30 minute checks back in April 2013 and could not remember when she was taken off 30 minute checks.</p> <p>On 7/17/13 at 1:45 p.m., LN #3 was interviewed and asked if Resident #5 was on 30 minute checks. LN #3 said the resident was on 30 minute checks while in bed and was to be in line of sight when the resident is up in her wheel chair. The surveyor informed LN #3 that CNA #1 said they (CNAs) were not doing 30 minute checks on the resident. LN #3 said she was under the impression the 30 minute checks were still being done.</p> <p>On 7/17/13 at 2:15 p.m. the DNS was notified related to the concern about Resident #5 not being checked every 30 minutes as directed by the resident's Care Plan. The DNS did not provide any additional information or documentation as to why the 30 minute checks were not being done for Resident #5.</p>	F 323		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135097	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/19/2013
NAME OF PROVIDER OR SUPPLIER ASHTON LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 700 NORTH 2ND STREET ASHTON, ID 83420		
(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 431 F 431 SS=E	Continued From page 5 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:	F 431 F 431	Specific Resident - All unlabeled insulin pens were discarded on the day they were discovered unlabeled by the survey team. New pens were opened and labeled starting that 7/18/2013. Other Residents - All residents have ability to be affected. All unlabeled insulin pens were discarded on the day they were discovered unlabeled by the survey team. New pens were opened and labeled starting that 7/18/2013. Systemic Changes - Charge Nurse meeting on July 24—nurses were reminded that any multi-use medication must be dated when opened, and insulin pens will now be kept at room temp after opening. Information on length of effectiveness after opening of each kind of insulin will be kept on the container of open pens as a reminder of when each is outdated. The pharmacy are providing stickers to be placed on each pen when it is opened specific for labeling the pens with date opened and date of expiration. Monitor - Starting 8/2/2013 DNS to audit insulin pens daily for one month, then weekly for 3 months for date opened on each. Checking insulin pens for date opened has been added to day shift LN check list. DNS will report to QA committee results of checks.	8/13/2013	

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

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135097	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/19/2013
NAME OF PROVIDER OR SUPPLIER ASHTON LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 700 NORTH 2ND STREET ASHTON, ID 83420	
(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 431	<p>Continued From page 6</p> <p>Based on observation, staff interview, and record review, it was determined the facility failed to store unopened insulin properly and ensure it was not expired or outdated. This was true for 7 of 7 Insulin Pens and 2 of 2 multidose vials of Insulin stored in the medication refrigerator. This failed practice created the potential for residents to receive expired insulin. Findings include:</p> <p>NOTE: Insulin used after the manufacturer's specified guidelines may result in decreased strength of the medication and can potentially increase residents risk for elevated blood sugars. Manufacturer's specifications are different for different insulins, for example:</p> <p>*Levemir Flex Pen, "can be kept unrefrigerated at room temperature...Unrefrigerated LEVEMIR should be discarded 42 days after it is first kept out of the refrigerator..."</p> <p>*Humalog Kwik Pen, "Keep at room temperature for up to 28 days. Throw away a used Kwik Pen after 28 days, even if there is insulin left..."</p> <p>*Lantus Solostar Pen, "unopened or opened insulin pen at room temperature should be discarded after 28 days."</p> <p>*Novolin 70/30 multidose vial, "Opened vials should be kept at room temperature for up to 6 weeks (42 days). Throw away any opened vials after 6 weeks (42 days) of use even if there is insulin left in the vial."</p> <p>*Humalog multidose vial, "Keep at room temperature for up to 28 days. Throw away any opened vials after 28 days, even if there is insulin left..."</p> <p>On 7/18/13 at 9:35 a.m., the medication refrigerator was checked for expired medications. Findings include: - 4 Lantus Solostar Pens without a date opened</p>	F 431		

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

PRINTED: 08/23/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135097	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/19/2013
NAME OF PROVIDER OR SUPPLIER ASHTON LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 700 NORTH 2ND STREET ASHTON, ID 83420		
(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 431	Continued From page 7 or expiration date, - 1 Humalog Kwik Pen without a date opened or expiration date, - 2 Levemir Flex Pen without a date opened or expiration date, - 1 Novolin 70/30 multidose vial without a date opened or expiration date, - 1 Humalog multidose vial without a date opened or expiration date. On 7/18/13 at 10:00 a.m., the DNS was informed and interviewed about the above findings. She said she was not aware that the insulin pens and multidose vials did not have the opened or expiration dates on them. The DNS said the open insulin pens and vials without open dates would be discarded and the facility would coordinate with the pharmacy for information on storage and expiration dates of each insulin in use.	F 431			

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001010	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/19/2013
NAME OF PROVIDER OR SUPPLIER ASHTON LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 700 NORTH 2ND STREET ASHTON, ID 83420		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	16.03.02 INITIAL COMMENTS The 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 State licensure survey of your facility. The surveyors conducting the survey were: Karen Marshall, MS, RD, LD Team Coordinator Rebecca Thomas, BSN, RN Amy Jensen RN	C 000		
C 159	02.100.09 RECORD OF PTNT/RSDNT PERSONAL VALUABLES 09. Record of Patient's/Resident's Personal Valuables. An inventory and proper accounting shall be kept for all valuables entrusted to the facility for safekeeping. The status of the inventory shall be available to the patient/resident, his conservator, guardian, or representative for review upon request. This Rule is not met as evidenced by: Please refer to F204 as it related to accounting for a resident's belongings at discharge.	C 159	Refer to F204	8/13/2013
C 790	02.200.03,b,vi Protection from Injury/Accidents vi. Protection from accident or injury; This Rule is not met as evidenced by: Please refer to F 323 as it relates to accident prevention.	C 790	Refer to F323	8/13/2013

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FACILITY STANDARDS

Bureau of Facility Standards

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

TITLE

(X6) DATE

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001010	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/19/2013
NAME OF PROVIDER OR SUPPLIER ASHTON LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 700 NORTH 2ND STREET ASHTON, ID 83420		
(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 798	Continued From page 1	C 798		
C 798	02.200,04,a MEDICATION ADMINISTRATION Written Orders 04. Medication Administration. Medications shall be provided to patients/residents by licensed nursing staff in accordance with established written procedures which shall include at least the following: a. Administered in accordance with physician's dentist's or nurse practitioner's written orders; This Rule is not met as evidenced by: Please refer to F 281 as it relates to administration of medication.	C 798	Refer to F281	8/13/2013
C 821	02.201,01,b Removal of Expired Meds b. Reviewing all medications in the facility for expiration dates and shall be responsible for the removal of discontinued or expired drugs from use as indicated at least every ninety (90) days. This Rule is not met as evidenced by: Please refer to F431 as it relates to labeling and storage of medications.	C 821	Refer to 431	8/13/2013
C 882	02.203,02,a Resident Identification Requirements a. Patient's/resident's name and date of admission; previous address; home telephone; sex; date of birth; place of birth; racial group; marital status; religious preference; usual occupation; Social Security number; branch and dates of military service	C 882	Other Residents - All residents discharges have potential to be affected. All discharges since survey 7/19/2013 have had an appropriate diagnosis upon discharge.	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001010	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/19/2013
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NAME OF PROVIDER OR SUPPLIER ASHTON LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 700 NORTH 2ND STREET ASHTON, ID 83420
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C 882	<p>Continued From page 2</p> <p>(if applicable); name, address and telephone number of nearest relative or responsible person or agency; place admitted from; attending physician; date and time of admission; and date and time of discharge. Final diagnosis or cause of death (when applicable), condition on discharge, and disposition, signed by the attending physician, shall be part of the medical record.</p> <p>This Rule is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure the Discharge Summary contained the cause of death or final diagnosis. This affected 1 of 1 (#10) closed records reviewed. Findings included:</p> <p>Resident #10 was admitted to the facility on 12/21/12 with multiple diagnoses including depressive disorder. On 5/5/13 the resident discharged from the facility.</p> <p>The resident's 5/6/13 Discharge Summary contained a section for Final Diagnoses/Condition Upon Discharge. This section contained the word, "deceased."</p> <p>On 7/18/13 at 9:00 a.m., the surveyor informed the DON the resident's Discharge Summary did not contain a final diagnosis or cause of death. The DON reviewed the Discharge Summary and stated, "We need to put the final diagnosis on the Discharge Summary."</p>	C 882	<p>Systemic changes - the form was amended to the addition of "or Cause of Death." and "Final Diagnosis/Condition Upon Discharge". To prompt staff filling out form to add to discharge for all patients. Corrected on 7/22/2013</p> <p>Monitor - MDS coordinator will monitor discharges starting 8/2/2013 weekly for 4 weeks than monthly for 2 months. They will report to QA committee findings.</p>	8/13/2013
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