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
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CERTIFIED MAIL: 7012 3050 0001 2128 3399

September 4, 2014

Craig Johnson, Administrator
Boundary County Nursing Home
6640 Kaniksu Street
Bonners Ferry, ID 83805-7532

Provider #: 135004

Dear Mr. Johnson:

On **August 21, 2014**, a Recertification and State Licensure survey was conducted at Boundary County Nursing Home by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. This survey found the most serious deficiency to be an isolated deficiency 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 sign both the 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 **September 17, 2014**. Failure to submit an acceptable PoC by **September 17, 2014**, may result in the imposition of civil monetary penalties by **October 7, 2014**.

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

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;

- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;

- What measures will be put in place or what systemic change will you make to ensure that the deficient practice does not recur;

- How the corrective action(s) will be monitored to ensure the deficient practice does not recur, i.e., what quality assurance program will be put into place. This monitoring will be reviewed at the follow-up survey as part of the process to verify that the facility has corrected the deficient practice. Monitoring must be documented and retained for the follow-up survey. In your Plan of Correction, please be sure to include:

  a. Specify by job title who will do the monitoring.
     * It is important that the individual doing the monitoring have the appropriate experience and qualifications for the task.
     * The monitoring cannot be completed by the individual(s) whose work is under review.

  b. Frequency of the monitoring; i.e., weekly x 4, then q 2 weeks x 4, then monthly x 3.
     * A plan for "random" andits will not be accepted.
     * Initial audits must be more frequent than monthly to meet the requirement for the follow-up.

  c. Start date of the audits;

- Include dates when corrective action will be completed in column (X5).

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

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

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

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS), if your facility has failed to achieve substantial compliance by **September 25, 2014 (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 **September 25, 2014**. A change in the seriousness of the deficiencies on **September 25, 2014**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **September 25, 2014** includes the following:

Denial of payment for new admissions effective **November 21, 2014**. [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 **February 21, 2015**, if substantial compliance is not achieved by that time.

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

If you believe these deficiencies have been corrected, you may contact Lorene Kayser, L.S.W., Q.M.R.P. or David Scott, R.N., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional

Office or the State Medicaid Agency beginning on **August 21, 2014** 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 **September 17, 2014**. If your request for informal dispute resolution is received after **September 17, 2014**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, comments or concerns, please contact Lorene Kayser, L.S.W., Q.M.R.P. or David Scott, R.N., Supervisors, Long Term Care at (208) 334-6626.

Sincerely,

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

LKK/lj
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135004		08/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOUNDARY COUNTY NURSING HOME	6640 KANIKSU STREET BONNERS FERRY, ID 83805

(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: Amy Barkley, RN, BSN, Team Coordinator and Susan Gollobit, RN. The survey team entered the facility on 8/18/2014 and exited the facility on 8/21/14. Survey definitions: CNO = Chief Nursing Officer	F 000	All dates indicated are for the year 2014. 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. RECEIVED OCT 14 2014 FACILITY STANDARDS	
F 154 SS=D	483.10(b)(3), 483.10(d)(2) INFORMED OF HEALTH STATUS, CARE, & TREATMENTS The resident has the right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. The resident has the right to be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure that 2 (# 5, 6) of 2 sampled residents with dementia, who were reviewed for the use of antipsychotics, were provided risk versus benefits to include the potential for death. The deficient practice had the potential to cause more than minimal harm when residents # 5 and # 6 had a diagnosis of	F 154	F-154 Corrective Action: Resident #5 and #6 Risk/Benefit form completed to include "potential risk of death caused by cardiovascular disease or infection" Identification of Residents with Potential to be affected: All residents receiving any antipsychotic were reviewed for appropriate documentation of risk/benefit of anti-psychotic medication. Those residents whose Risk/Benefit consent form did not include "risk of death caused by cardiovascular disease or infection" were updated to include these risks and appropriate consent received from responsible party after review of added risks. Systemic changes: "Anti-psychotic medication form was created and implemented to list possible side effects/Risks to include:	09/16/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	CEO	10/9/2014

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 154	Continued From page 1 dementia and were not provided the information that the drug Seroquel could cause death. Findings included: *Nursing 2014 Drug Handbook, page 1177. Seroquel: "Black Box Warning. Drug isn't indicated for use in elderly patients with dementia-related psychosis because of increased risk of death from CV (cardio vascular) disease or infection." 1. Resident # 6 was admitted to the facility on 9/25/13 with diagnoses that included Alzheimer's disease, psychotic mood disorder, congestive heart disease, and anxiety. The resident's current physician recapitulation orders, dated 8/1/14, documented: *Quetiapine Fumarate (Seroquel) 12.5 mg (milligrams) po (by mouth) at 10:00 (AM). *Quetiapine Fumarate (Seroquel) 50 mg po at 1700 (5 PM). The resident's Psychoactive Medication Informed Consent form dated 1/7/14, which was signed by the resident's daughter, documented: *Medication Intervention Recommended: -"Seroquel (on admit) 25 mg at 7 p.m., 12.5 mg at 10 A.M. orally." *Purpose the Psychoactive Medication is Indicated: -Possible Side Effects/Risks Identify source used for Review- "dizziness, extrapyramidal symptoms, seizures." Note: The education for the side effects of Seroquel, which included death, was not provided to the resident or family member.	F 154	F-154: (Continue) "risk of death caused by cardiovascular disease or infection" printed on the form for review prior to consent (instead of handwritten) Responsible Party:CNO/Designee Completion Date: 09/10/2014 Quality Monitoring: Every residents receiving anti-psychotics will discuss Risk/adverse side-effects of antipsychotics including risk of death from cardiovascular disease or infection with resident or responsible party prior to giving/refusing consent of anti-psychotic. Responsible Party: CNO/Chief Nursing Officer/Nursing Staff Frequency of Monitoring: * Every resident admitted with antipsychotic medications * Every resident with antipsychotic medications ordered *Behavioral Management Monthly Review off all residents receiving antipsychotics.	09/16/14

L Johnson LSW 10/9/14

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F 154	Continued From page 2 *Statement of consent: The consent section of the form for the use of the Seroquel had 3 areas to check with different options which included consent for use, consent for temporary use, or no consent for the use of the medication. None of the three boxes were checked. On 8/20/14 at 4:10 PM, the surveyor asked the CNO (Chief Nurse Officer) if the facility had documentation that it had provided the risk of death when the informed consent for Seroquel had been provided to the resident's family. The CNO stated she had spoken to the Bureau of Facilities Chief [Idaho Department of Health and Welfare] about that about 2 weeks prior. The CNO stated she had brought the information back to the facility's Medical Director, and he was working on it. The informed consent for the resident was reviewed with her and she agreed the risk of death was not on it. The CNO stated she would look to see if it was documented in the chart. On 8/20/14 at 5:45 PM, the CNO stated to the surveyor she had not found documentation that the facility provided the risk of death with the use of Seroquel in the resident's paperwork. The surveyor reviewed the requirement to inform the resident and/or guardian of the risk of death with the use of Seroquel and the CNO stated she was not aware of the requirement for dementia residents. 2. Resident #5 was admitted to the facility on 6/13/13 with diagnoses that included, non-Alzheimer's dementia, psychotic disorder, and schizophrenia.	F 154		

S Johnson CEO, 10/9/14

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F 154	Continued From page 3 The resident's current physician recapitulations orders dated 8/1/14, documented: *Quetiapine Fumarate (Seroquel) 12.5 mg (milligrams) po (by mouth) at 8:00 (AM). *Quetiapine Fumarate (Seroquel) 25 mg po at 1900 (7 PM). The resident's Psychoactive Medication Informed Consent form dated 2/4/13, which was signed by the resident's daughter, documented: *Medication Intervention Recommended: -"Seroquel 25 mg 1/2 tab(let) = 12.5 mg twice daily." *Purpose the Psychoactive Medication is Indicated: -Possible Side Effects/Risks Identify source used for Review- "dizziness, extrapyramidal symptoms, sedation, postural hypotension." *Statement of Consent: - The box checked was: "I do desire the use of the medication(s) indicated above and do consent to their use." Note: The education for the side effects of Seroquel, which included death, was not provided to the resident or family member. On 8/20/14 at 4:10 PM, the surveyor reviewed the Psychoactive medication informed consent for the resident with the CNO, and asked if the facility had provided the information for the use of Seroquel and death. The CNO said the information was not on the form and stated she would look for it in the chart.	F 154		

S Johnson CEO/ 10/9/14

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F 154	Continued From page 4 On 8/20/14 at 5:45 PM, the CNO stated she had not found documentation that the facility provided the risk of death with the use of Seroquel in the resident's paperwork. On 8/21/14 at 3:30 PM the Administrator and the CNO were informed of the findings. No additional information was provided.	F 154		
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 observation, staff/resident interview, and record review it was determined the facility did not ensure the following: - A cabinet, in the beauty parlor with potentially hazardous liquids was locked; - Efferdent tablets were not accessible to a resident with a known history of dissolving and drinking Efferdent; and - A resident with three reported cigarette burns received increased supervision while smoking. This was true for 2 of 9 sampled residents (#1 & #5), and all ambulatory residents in the facility. This failed practice had the potential for harm if Resident #5 drank the Efferdent and other residents drank the potentially hazardous liquids	F 323	F323- Hazardous Materials in Beauty Room Action Plan: All hazardous materials removed from cabinet. - Beauty room cabinet assessed and lock remediated - Sign applied to cabinet door "cabinet doors must be locked" - Beauty Room Door handle replaced with self-locking handle - Sign posted on door "Keep door closed when room not in use" - All rooms containing potentially hazardous materials assessed for self-locking door handles - Self locking door handles present on all other rooms containing potentially hazardous materials Quality Monitoring: Beauty Room will be checked Q shift to insure door is closed and locked. Staff to initial log sheet. Frequency: Q Shift x 1 month Responsible Party: Licensed staff	09/25/14

S Johnson 10/9/14

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F 323	Continued From page 5 and required emergency medical services. Additionally, Resident #1 was at risk for harm if he were to drop a lit cigarette or hot ash on himself and receive a second or third degree burn. 1. Resident #1 was admitted to the facility with multiple diagnoses to include chronic pain, neurogenic bladder, quadriplegia, c-spine injury, and spasticity. The resident's most recent Quarterly MDS dated 6/10/14 coded the following: - Cognitively intact with a BIMS score of 13. - Extensive assist of two people for bed mobility, transfers, and dressing. - Independent with locomotion on and off the unit. - Supervision with one person assist for eating. - Functional limitation in bilateral upper and lower extremities. The resident's Self-Care Deficit care plan documented the following: - 8/31/11, "Resident able to smoke independently after set up with adaptive equipment and protective cover worn around neck to protect chest and lap." - 6/18/14, "Do not assist him [Resident #1] to smoke, such as putting hand to mouth for cigarette smoking." The resident's Safe Smoking Assessment dated 12/28/11 documented the following: - "RSDT [resident] alert and oriented and able to make his own decisions." - Needs assistance [with] lighting cig[arette] but has tool made for smoking independence once lit. A Confidential Quality Management Occurrence	F 323	F323- Facility identification of root cause for cigarette burns: Root cause for cigarette burns: Resident is unable to safely manage any aspect of smoking activity independently due to physical and sensory impairments related to C-spine Injury. Action Plan: Prevent resident from receiving burns in the future: - Resident will be provided with choice of electronic cigarette or tobacco cigarette. If resident requests electronic cigarette, staff to escort and set-up including smoking apron. - Resident may smoke independently. - If resident requests tobacco cigarette resident will be provided smoking apron. Staff will escort and set-up cigarette utilizing "Remote Smoker Ashtray" (see photos) and provide direct supervision for the entire duration of smoking activity. - Fire extinguisher and first-aid blanket mounted on pillar for immediate access in the event of emergency. - Smoking Apron has been replaced with one that provides protection of the neck and chest (ash fell down front of resident between apron and shirt)	09/25/14

S Johnson CEO 10/9/14

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F 323	Continued From page 6 report dated 1/22/14 documented the following: * "Noted 1 cm cigarette burn on left medial thigh." * Investigation - "No sign of infection noted. Resident unaware when this happened. It was not there on 1/20/14 when catheter flushed. Resident wears smoking apron every time he goes out to smoke. It appears to be placed appropriately when I observed it." A Confidential Quality Management Occurrence report dated 6/27/14 documented the following: * "Probable cigarette burn top of Right thigh." * Additional description of event - "Resident denies knowing about burn, or when it happened." * Need for additional monitoring due to injury, medication - "Monitor daily for s/sx [signs and symptoms] of infection. * Patient/Resident interview - "RSDT [resident] not concerned about wound and knows risks of continuing to smoke." * Care plan updated, "No." * Follow-up by department manager/director - "Staff reminded to make sure smoking apron is tucked in at the sides, between w/c [wheelchair], and legs." A Confidential Quality Management Occurrence report dated 8/11/14 documented the following: * "Resident's cigarette fell, landing in small gap at the top of his protective apron. Received small 0.5 cm light burn to skin. Care for area given." * Follow-up by department manager/director - "Encouraged him to change to E-cigarette, note added to 'Brain' to monitor apron - making certain top edge is high under chin and no gaps remain for his cigarette to drop into." Note: "Brain" refers to the facility's 24 hour	F 323	F-323 (cont) Monitor effectiveness of action plan: - Staff to document on log sheet choice of cigarette that was set-up and initial log sheet. - Safe smoking assessment to be completed with each MDS assessment to include safe demonstration of remote smoker ashtray and electronic cigarette Frequency: - Documentation of smoking: every smoking activity - Safe Smoking Assessment - Quarterly, Annual and Change of Status Identify and Monitor resident's skin for burns: - Skin assessment to be completed weekly and with bathing. Responsible Party: License Nurse Monitor when smoking: - Interdisciplinary staff members assigned to supervise Smoking Agreement: Reviewed with Resident - Copy of Facility "Tobacco Free Workplace" reviewed and understands and agrees to abide by the policy - (Yes) - Resident understands the need to wear a smoking apron for safety - (Yes)	

S Johnson CEO 10/9/14

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F 323	Continued From page 7 nursing report. On 8/19/14 at 9:00 AM the resident was observed to have a dark green fleece sweatshirt on. The sweatshirt was observed to have 12 cigarette burn holes down the front of it ranging in size from pin hole to quarter. On 8/21/14 at 9:00 AM the CNO was asked for the facility's smoking policy and procedure. The CNO stated the facility was a non-smoking facility and therefore there was no policy. The surveyor stated that Resident #1 smoked. The CNO stated he was grandfathered when the facility decided to prohibit smoking. On 8/21/14 at 2:30 PM, LN #1 was asked if the facility completed a Safe Smoking Assessment on the resident after all or any of the three identified burns. LN #1 stated she was unable to find a current Safe Smoking Assessment and the facility had not completed the assessment after any of the identified burns. On 8/21/14 at 3:00 PM, the CNO and LN #1 were interviewed. LN #1 stated the facility has counseled the resident multiple times on smoking cessation and the resident declined. The surveyor asked what changes were made to the resident's smoking interventions after each burn, and how did the facility monitor the effectiveness and modify those interventions. The CNO stated there have been no changes made to the resident's smoking interventions since August of 2011 because the resident's ability to smoke independently after set-up had not changed. The surveyor asked if the facility had increased supervision of the resident while he smokes. The CNO stated staff is not currently providing	F 323	F323(cont) - Resident will comply with arranged smoking schedule - (No) * Resident unable to set-up/light his own cigarettes. - Resident understands that smoking near residents with oxygen in use is prohibited - (Yes) - Resident understands needs for restrictions on smoking during inclement weather - (Yes) - Resident agrees to respect others right to use the patio without smoke - (Yes) - Resident understands that refusal to abide by this agreement could result in discharge from this facility - (No) * Resident unable to set-up/ light cigarettes. Monitoring of adherence to agreement: Not-applicable as resident is unable to smoke without staff assist to patio, set-up of cigarette/smoking activity.	

B Johnson CEO 10/9/14

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F 323	Continued From page 8 increased supervision. The surveyor asked if the facility should have provided increased supervision given the three burns in 2014. The CNO stated the facility would like to research different alternatives because the resident insists on smoking five cigarettes before breakfast and it would require a staff member to be pulled off of the floor. The CNO then stated, "It is the facility's responsibility to keep the residents safe." No additional information was provided to resolve this issue. 2. On 8/21/14 at approximately 9:10 AM, while on tour with the Plant Operation Manager (POM), the surveyor observed the Personal Grooming room, which also housed the beauty parlor. The door to the room was open and inside above the sink was a white cabinet with two doors. The door on the left was not locked and easily accessible. The cabinet contained the following items: *2 boxes of Insite- Low Thio-Ammonia free Hair Perm solution. *1 unmarked plastic spray bottle with clear liquid inside. *1 bottle of Wave Neutralizer. *Various brands of bottles of hair shampoo and hair conditioners. *Various bottles of hair styling gels. The surveyor verified with the POM the concern of these products being accessible to resident and she agreed it was a concern. On 8/21/14 at 10:05 AM, and 10:40 AM, the surveyor observed the cabinet door remained unlocked. On 8/21/14 at 11:20 AM, the surveyor observed the cabinet. The door was locked with a sign on it which stated, "Cabinet doors must be locked."	F 323		

S D Johnson CEO 10/9/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135004		08/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOUNDARY COUNTY NURSING HOME	6640 KANIKSU STREET BONNERS FERRY, ID 83805

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F 323	Continued From page 9 On 8/21/14 at 11:25 AM, the surveyor asked the CNO (Chief Nurse of Operations) if she was aware of the closet being open and the products inside easily accessible to residents. She stated, "Yes, they told me. We are also going to lock the door to the room." On 8/21/14 3:30 PM, during end of day with the Administrator, the surveyor described the cabinet to him and he stated it was a problem and "that's why there is a lock on it."	F 323		
	3. Resident #5 was admitted to the facility on 6/13/13 with diagnoses that included, non-Alzheimer's dementia, psychotic disorder, and schizophrenia. The resident's Quarterly MDS (Minimum Data Set), dated 8/4/14, documented: Resident's cognition was moderately impaired and she was able to ambulate independently in her room. The resident's care plan documented: *Problem: "(Resident's name) has alteration in self-care related to: 1. Dementia. 2. Hyponatremia 3. HX (history) sinus headaches as exhibited by: Mild confusion 2. Requires cueing and Supervision 3. Short Term Memory loss 4. Unsteady on her feet 5. Poor safety awareness." *Interventions: -"Do not keep Efferdent or its equivalent in (resident's name) room. Evening staff to supply one and assist her in its use during HS (hour of sleep) care." Dated 3/24/2013. On 8/20/14 at 12:10 PM, the surveyor observed a clear plastic container next to the resident's sink. The container had 1 package with Efferdent written on it. The package was unopened. The		#3 - Resident#5 - Efferdent tablets accessible to resident with hx of dissolving and drinking Efferdent Root Cause: Failure to remove Efferdent tablet from clear plastic container filled with straws and pink mouth sponges after decision that "it was not safe to leave in her room" Action Plan #5: All potentially hazardous items removed from room. - All items labeled and stored in medication room behind nurses station Monitoring: Room check every shift to insure no hazardous items in room. Frequency: Every shift Responsible Party: Licensed Nurse	09/25/14

10/9/14

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F 323	Continued From page 10 container also contained straws and pink mouth sponges. On 8/21/14 at 11:30 AM, the surveyor observed the clear plastic container next to the resident's sink. The container had 1 package with Efferdent written on it. The package was unopened. The container also contained straws and pink mouth sponges. On 8/21/14 at 11:35 AM, the surveyor with LN#1 observed the Efferdent packet in the plastic container by the resident's sink. LN#1 removed the packet and stated, "That's not a good thing." The surveyor asked LN #1 why the resident was not allowed to have Efferdent in her room. LN #1 stated, "She put it in a cup and drank it. She thought it was Alka Seltzer so we decided that it would not be safe. The family brings it in to her." On 8/21/14 at 3:30 PM the Administrator and the CNO were informed of the findings. No additional information was provided.	F 323	F323- Ensure residents do not have access to hazardous chemicals. Action Plan: All resident rooms audited for hazardous chemicals completed. No hazardous chemicals found. Monitoring: Monthly checks of each room to insure no hazardous materials present. Frequency: Monthly during "unit week" Responsible Party: Licensed Nurse/ Designee	09/25/14

S Johnson CEO 10/9/14

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	MDS001070		08/21/2014

NAME OF PROVIDER OR SUPPLIER: BOUNDARY COUNTY NURSING HOME

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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 State licensure survey of your facility. The surveyors conducting the survey were: Amy Barkley, RN, BSN, Team Coordinator Susan Gollobit, RN The team entered the facility on 8/18/14 and exited on 8/21/14.	C 000	RECEIVED OCT 14 2014 FACILITY STANDARDS	
C 119	02.100,03,c,iii Informed of Medical Condition by Physician iii. Is fully informed, by a physician, of his medical condition unless medically contraindicated (as documented, by a physician, in his medical record), and is afforded the opportunity to participate in the planning of his medical treatment and to refuse to participate in experimental research; This Rule is not met as evidenced by: Refer to F154 related to informed consent.	C 119	Refer to F-154 for Plan of Correction	
C 342	02.108,04,b,ii Toxics Stored Under Lock and Key ii. All toxic chemicals shall be properly labeled and stored under lock and key. This Rule is not met as evidenced by: Refer to F323 related to improprly stored chemicals.	C 342	Refer to F-323 for Plan of Correction	

Bureau of Facility Standards
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: CEO (X6) DATE: 10/9/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	MDS001070		08/21/2014

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C 664	02.150,02,a Required Members of Committee a. Include the facility medical director, administrator, pharmacist, dietary services supervisor, director of nursing services, housekeeping services representative, and maintenance services representative. This Rule is not met as evidenced by: Based on staff interview and review of the Infection Control Committee (ICC) meeting attendance records, it was determined the facility did not ensure the Administrator and the Pharmacist attended/participated in quarterly ICC meetings. This failure created the potential for a negative effect for all residents, staff and visitors in the facility when ICC members were not involved in the ICC meetings. Findings included: On 8/21/14 at 11:15 AM, the surveyor asked the CNO (Chief Nurse Officer) whether the Administrator attended the ICC meetings, and she stated, "He does not." The surveyor asked if the Pharmacist attended the meetings and the CNO stated, "He doesn't." On 8/21/14 at approximately 11:20 AM, the surveyor was provided the sign-in sheets for the quarterly ICC meeting which were dated, 1/28/14, 4/22/14, and 7/22/14; neither the Administrator nor the Pharmacist were in attendance. On 8/21/14 at 3:30 PM, the Administrator and CNO were informed of the findings. No additional information was provided.	C 664	Administrator and Pharmacist will attend Quarterly Infection Control meetings Next meeting scheduled: Tuesday, October 21, 2014 at 11:00 a.m. Quality Monitoring: Review of Attendance sign-in sheets Quarterly/One year Responsible Party: Infection Prevention Manager Compliance date is 10/21/14 per Craig Johnson Administrator per telephone call 10/23/14 at 0945 Am. Susan Dollett RN H 33591	
C 790	02.200,03,b,vi Protection from Injury/Accidents vi. Protection from accident or injury;	C 790	Refer to F-323 for Plan of Correction	

S Johnson CEO 10/9/14

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C 790	Continued From page 2 This Rule is not met as evidenced by: Please refer to F323 as it relates to accidents.	C 790		

S Johnson CEO 10/9/14