



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
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CERTIFIED MAIL: 7012 1010 0002 0836 2250

September 12, 2013

Bonnie Sorensen, Administrator
Countryside Care & Rehabilitation
1224 8th Street
Rupert, ID 83350-1527

Provider #: 135064

RE: RECERTIFICATION AND STATE LICENSURE SURVEY REPORT COVER LETTER

Dear Ms. Sorensen:

On **August 29, 2013**, a Recertification and State Licensure survey was conducted at Countryside Care & Rehabilitation 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**

Bonnie Sorensen, Administrator
September 12, 2013
Page 2 of 4

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 **September 25, 2013**. Failure to submit an acceptable PoC by **September 25, 2013**, may result in the imposition of civil monetary penalties by **October 15, 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

Bonnie Sorensen, Administrator
September 12, 2013
Page 3 of 4

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 **October 3, 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 **October 3, 2013**. A change in the seriousness of the deficiencies on **October 3, 2013**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **October 3, 2013** includes the following:

Denial of payment for new admissions effective **November 29, 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 **March 1, 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.

Bonnie Sorensen, Administrator
September 12, 2013
Page 4 of 4

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 29, 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 **September 25, 2013**. If your request for informal dispute resolution is received after **September 25, 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: 09/09/2013
FORM APPROVED
OMB NO. 0938-0391

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|--|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135064 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 08/29/2013 |
| NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE CARE & REHABILITATION | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1224 8TH STREET RUPERT, ID 83350 | |
| (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 | <p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the annual recertification survey of your facility.</p> <p>The surveyors conducting the survey were:</p> <p>Karen Marshall, MS, RD, LD Team Coordinator Karla Gerleve, RN</p> <p>Survey Definitions: BFS = Bureau of Facility Standards DON = Director of Nursing LN = Licensed Nurse MAR = Medication Administration Record MDS - Minimum Data Set assessment ML = Milliliters MG = Milligram OZ = ounces PO = By mouth PRN = As needed Q = Every TAB = Tablet</p> | F 000 | <p>RECEIVED SEP 23 2013 FACILITY STANDARDS</p> <p><i>Start date of audits: 9.10.13 per telephone call to Admin. 9.10.13 is the start date for all audits. LM</i></p> | |
| F 272 SS=D | <p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS</p> <p>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns;</p> | F 272 | <p>F- 272</p> <ol style="list-style-type: none"> 1. Resident #6, Resident #2 side rails have been assessed for safety and appropriateness. 2. All residents with side rails will have their Side Rail Assessment reviewed for completeness, appropriateness, and safety. 3. Staff was inserviced concerning side rail assessments on 9-9-13, this deficiency will again be reviewed in a staff meeting on 9-23-13. 4. The DON or her representative will do a weekly QA of all Side Rail Assessments for new admissions, change of conditions, and residents who have had annual or quarterly re-assessments until 100% compliance is met for 4 weeks. Then QA monthly until 100% is achieved for 3 months. Then QA quarterly. Findings of the QA checks will be reported to the administrator at the monthly QA committee. | 9/20/13 |

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

TITLE

(X6) DATE

Bonnie Sorensen

Administrator

9-20-13

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.

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| F 272 | Continued From page 1 Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to provide accurate and completed side rail assessments. This had the potential to put the residents at risk of entrapment and harm and affected 2 of 9 (#s 2 and 6) sampled residents. Findings included: 1. Resident #6 was admitted to the facility on 3/1/12 and readmitted on 1/1/13 with diagnoses of dementia, hypothyroidism, and left sided weakness. | F 272 | | | |

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| F 272 | <p>Continued From page 2</p> <p>Resident #6's 2/12/13 annual MDS documented in part: -Short and long term memory problem -Moderately impaired cognitive skills -Extensive assistance of one person for bed mobility -Total dependence of two persons for transfers.</p> <p>Resident #6's 8/1/13 quarterly MDS documented in part: -Short and long term memory problem -Moderately impaired cognitive skills -Total dependence of two persons for bed mobility and transfers.</p> <p>Resident #6's August 2013 Recapitulation Orders documented in part: "Side Rails Used: Per Side Rail Assessment [SRA]."</p> <p>Resident #6's Care Plan contained a problem "Alteration in Mobility" and an intervention was "Side rails per side rail assessment."</p> <p>Resident #6's 7/20/13 SRA form documented the resident had underlying conditions that might place him at risk for entrapment. The conditions were: Cognitive/mental changes/Behaviors, Incontinence/urgency, and, Inability to adequately communicate needs/problems. The form contained a question: "Can or has interventions be put into place to reduce eliminate the risk of entrapment? Handwritten in response to the questions was: "Res [Resident] with Dementia. Family requests use of siderails no change in orders."</p> | F 272 | | |

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| F 272 | <p>Continued From page 3</p> <p>The back of the SRA contained questions regarding safety of the side rails. These Safety questions were all blank. The back of the form also contained the following information: -Recommendation/Determinations-Half Rails: left and right.</p> <p>Resident #6 also had SRAs dated 4/16/13 and 3/1/12. The back page of all the SRAs regarding questions of safety with the use of the side rails were blank. They all documented in part: Recommendation/Determinations-Half Rails: left and right.</p> <p>On 8/27/13 at 10:55, the DON was informed of the concern of the SRA for Resident #6. All three SRAs were incomplete. They did not address whether the resident was safe with the use of the side rails. The DON said, "I didn't know the back of the form was not filled out, I will get a new SRA done."</p> <p>2. Resident #2 was admitted to the facility on 12/5/03 with multiple diagnoses including Alzheimer's dementia, depression, and history of glaucoma.</p> <p>Resident #2's 4/23/13 quarterly MDS coded severely impaired cognitive skills, required total assistance of one person for bed mobility, and extensive assistance of 2 persons for transfers.</p> <p>Resident #2's August 2013 Recapitulation Orders contained a 7/24/13 order for, "side rails used: per side rail assessment."</p> <p>Resident #2's 8/2/13 Comprehensive Care Plan contained the problem alteration in mobility. One of the interventions was, side rails per side rail</p> | F 272 | | | |

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| F 272 | <p>Continued From page 4 assessment.</p> <p>Resident #2's 11/23/11 SRA form contained a handwritten entry at the bottom of the first page, "Will attempt side rail reduction. Will [decrease] to 1 1/2 [one one-half] upper rail on [left] side. Will [decrease] rail on [right] side..." The SRA form also contained at the bottom of the second page a section titled Recommendations/Determinations. This section documented, "Based on the above assessment the following side rail Interventions have been determined to be appropriate for the resident:...Half Rails: Left [side of bed]..."</p> <p>Resident #2's SRA Quarterly & PRN contained the following:</p> <ul style="list-style-type: none"> - Instructions: Review the Resident's current comprehensive SRA. If there are no changes in the resident's use of the side rails, the nurse evaluator shall utilize this form. - Re-Evaluation, SRA was reviewed and determined to be appropriate. The handwritten Re-Evaluation dates were 10/4/12, 11/29/12, & 7/31/13. - Each of the Re-Evaluation dates contained handwritten entries the resident had "bilat 1/2 upper rails [bilateral one-half upper side rails]..." <p>Resident #2's 11/23/11 SRA form documented that based on the assessment, 1/2 rails to the left side of the bed were determined to be appropriate for the resident. However, the resident's re-evaluations all documented bilateral 1/2 upper side rails and the resident was observed with bilateral 1/2 upper side rails in the upright position while in bed (see below). The assessment and re-evaluations were not clear as to whether the facility assessed the resident for a</p> | F 272 | | |

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| F 272 | Continued From page 5 half rail on the left side of the bed or for the use of bilateral side rails. Please refer to F323 as it related to the resident's siderail. On 8/26/13 at 4:10 p.m., on 8/27/13 at 11:15 a.m. and 3:15 p.m., the resident was lying in bed with bilateral 1/2 upper side rails in the upright position. On 8/28/13 at 9:45 a.m., the left side rail was in the upright position on the resident's bed. The resident was sitting in a wheelchair in the activity area of the main dining room. On 8/28/13 at 11:30 a.m., the surveyor informed the DON the resident's siderail assessment and re-evaluations were not clear as to what siderail or siderails were assessed and re-evaluated for safety. The DON stated, "We will take a look at our assessment process." | F 272 | | | |
| 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 record review, it was determined the facility failed to ensure staff adhered to professional standards of practice while providing medications via a feeding tube and failed to follow physicians orders to give a | F 281 | | | |

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| F 281 | <p>Continued From page 6</p> <p>medications with 8 oz of fluid. This affected 1 of 11 (#11) residents during review of medication administration practices. This failed practice created the potential of harm to the resident if the prescribed medication were not delivered as ordered. Findings included:</p> <p>A) On 8/28/13 at 5:50 pm during observation of medication administration, LN #1 was observed pouring 15 ml of Silace Syrup into a 30 ml cup. LN#1 then poured the 15 ml of Silace Syrup into a clear plastic 8 oz cup. LN#1 opened a Dantrolene Sodium 50 mg capsule and poured the contents into the plastic cup with the syrup. LN#1 proceeded to put 2 tablets of Simethicone 80 mg, and 2 tablets of Oxycodone 5 mg, into a clear plastic bag. LN#1 crushed the two medications and poured the contents of the clear plastic bag into the clear cup that contained the other medication. LN#1 added a small amount of water (approximately 30 ml) to the cup with the medication and stirred it with a spoon. LN#1 checked for placement of the feeding tube for Random Resident #11, and flushed the feeding tube with 15 ml of water. LN#1 administered the medications, and flushed the feeding tube again with 25 ml of water. After leaving the room, the surveyor informed LN#1 of the concern of administering all the medications together into Resident #11's feeding tube without flushing between each medication.</p> <p>NOTE: CMS letter dated November 2, 2012 Ref: S&C: 13-02-NH stated in part: "For administering medication via tube feeding, the standard of practice is to administer each medication separately and flush the tubing between each medication."</p> | F 281 | <p>F-281</p> <ol style="list-style-type: none"> 1. Physician Orders were obtained to clarify medication order. The physician reviewed the medications and ordered that it is alright to give residents meds mixed together in fluid through PEG tube. An order was also obtained to change the order for the docusate sodium; it does not need to be flushed with 8 oz of fluid (the pharmacist reviewed the need for the docusate sodium to be flushed with 8 oz. of fluid water. The findings were that the docusate irritates the throat and needs to be followed by 8 oz of water. The resident does not take this orally and receives a sufficient amount of fluids otherwise to allow stools to be expelled without difficulty). 2. There were no other residents who use a feeding tube. 3. Staff was inserviced on 9/9/13 concerning the feeding tube medications. Another inservice will be done on 9/23/13. All new residents with feeding tubes will have medications reviewed by the physician and the pharmacist for medication interaction. 4. The DON or her representative will do a weekly QA to ensure medications are given per physician order, this will continue until 100% compliance is met for 4 weeks, then monthly until 100% compliance is met for 3 months, then quarterly. Findings of the QA checks will be reported to the administrator monthly at the QA committee meetings. | 9/20/13 |

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| F 281 | <p>Continued From page 7</p> <p>On 8/28/13 at 6:15 pm the DON was informed of administration of medications mixed together without flushing between each medication. No documentation or information was provided which resolved the issue.</p> <p>B) On 8/28/13 at 5:50 pm during observation of medication administration, LN#1 was observed administering 15 ml of Silace Syrup to Random Resident #11. The Silace Syrup medication prescription label read: "Silace Syrup (Docusate) 60 mg/15 ml 2x daily, Give with 8 oz fluid". The total ounces of fluid given during flushing and medication administration was less than 3 ounces. LN#1 did not administer 8 oz of fluid before, during, or after administering the Silace Syrup.</p> <p>Random Resident #11's August 2013, "Active Pharmacy Profile Report" (Physicians Recapitulation Orders) documented in part: "Docusate Sod. [Sodium] Liquid 60 MG/15 ML 15 ML = 60 MG peg tube two times daily, for Constipation Give w [with] 8 oz Fluid, Hold for Loose Stools".</p> <p>Random Resident #11's August 2013, Medication Administration Record (MAR) documented in part: Docusate SOD [Sodium] Liquid, Generic Colace (60 MG/15 ML), Dose: 15 ML = 60 MG peg tube two times daily for Constipation, Give w [with] 8 oz fluid, Hold for Loose Stools".</p> <p>On 8/28/13 at 6:15 pm, the DON was informed of administration of Silace Syrup to Random Resident #11 without providing 8 ounces of fluid per Physicians Orders. No documentation or information was provided which resolved the issue.</p> | F 281 | | | |

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| F 323 SS=E | <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, it was determine the facility failed to ensure the safety of a resident with cognitive impairment was maintained while the resident was in bed. This affected 1 of 3 (# 2) residents sampled for falls. In addition, unsecured laundry chemicals were observed in the laundry room. This affected 2 of 9 (#s 6 & 8) sampled residents and had the potential to affect all residents who resided on the West hall. This practice placed the residents at risk for more than minimal harm from falls and possible contact with chemicals used in the laundry. Findings included:</p> <p>1. Resident #2 was admitted to the facility on 12/5/03 with multiple diagnoses including Alzheimer's dementia, depression, and history of glaucoma.</p> <p>Resident #2's 4/23/13 quarterly MDS coded severely impaired cognitive skills, required total assistance of one person for bed mobility, extensive assistance of 2 persons for transfers, and one fall with no major injury.</p> <p>Resident #2's 8/13 Physician's Orders</p> | F 323 | <p>F-323</p> <ol style="list-style-type: none"> 1. Resident #2's side rails were checked to make sure they are locking securely. 2. All residents with side rails will have their side rails checked to make sure they are locking when in an upright position. 3. Staff was inserviced on 9/6/13 to check side rails when they are raised to make sure they are locking appropriately. Will include the question "Side rails lock securely when in an upright position" to the Side Rail Assessment. 4. The CNA Supervisor or her representative will do a weekly QA of all side rails for appropriate locking until 100% compliance is met for 4 weeks, then monthly until 100% compliance is met for 3 months, then quarterly. Findings of the QA checks will be reported to the administrator at the monthly QA committee meeting. <p>A locking cabinet has been placed in the Laundry room to store open and unopened chemicals in.</p> <p>Staff was inserviced on 9/16/13 of need to place chemicals in the cabinet and lock it at the end of the day. Locking of the cabinet was added to the daily laundry department check off list.</p> <p>The Director of Housekeeping and Laundry will do a weekly QA to be sure the cabinet is locked at the end of the day until 100% compliance is met for 4 weeks, then monthly until 100% compliance is met for 3 months, then quarterly. Findings of the QA checks will be reported to the QA committee meeting.</p> | 9/20/13 | |



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

PRINTED: 09/09/2013
FORM APPROVED
OMB NO. 0938-0391

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| F 323 | <p>Continued From page 9 (Recapitulation) contained a 7/24/13 order, "Siderails used: per siderail assessment."</p> <p>Resident #2's 8/2/13 Comprehensive Care Plan contained the problem, alteration in mobility. One of the interventions was, siderails per siderail assessment.</p> <p>Resident #2's 3/9/13 Fall Scene Incident/Investigation documented the resident sustained a laceration below the right eye and bruising around eye and bridge of nose. The section titled, Details of Exactly What Happened contained a handwritten entry, "Resident fell out of bed. She rolled over [and] siderail was not locked. (siderail was in [up] position). Siderail had caught on bedside table." The section title, Treatment/Follow Up contained a handwritten entry, "Steri-strips to below eye - make sure siderail is locked - Keep bedside table away while putting up siderails." The Nurse's Signature section was signed by the DON on 3/9/13. The section titled, What appears to be the root cause of the fall contained a handwritten entry, "Side rail did not lock in the [upright] position. Res [resident] plays [with] siderails while in bed. Siderail fell and res rolled out of bed."</p> <p>The facility initiated 72 hour monitoring. Review of Nursing Flow Sheets from 3/9/13 through 3/21/13 revealed the facility monitored the resident's condition and the resident did not require emergent care at the local hospital.</p> <p>Please refer to F272 as it related to assessing the use of the siderails for Resident #2.</p> <p>On 8/28/13 at 11:30 a.m., the surveyor informed the DON the resident fell out of bed and the</p> | F 323 | | |

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

PRINTED: 09/09/2013
FORM APPROVED
OMB NO. 0938-0391

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| F 323 | <p>Continued From page 10</p> <p>siderail was in the upright position but were not locked. The DON nodded her head in an up and down motion and said, "Yes, the resident did fall and the siderail was not secured."</p> <p>On 8/29/13 at 3:30 p.m., the Administrator was informed of the finding. The facility did not provide any additional information related to the finding.</p> <p>2. On 8/28/13 at 2:30 pm during general observations of the facility, the Director of Housekeeping and Laundry Services was asked where the Laundry Department stored their chemicals. The Director pointed to a wooden shelf in the corner of the Laundry Room. Multiple chemicals including "Stain Blaster", "Iodine & Betadine Remover", and "Orange Mist" were on an open shelf with no doors or locks. The Iodine & Betadine Remover had, "Keep Out of Reach of Children" on the label.</p> <p>The surveyor asked the Director of Housekeeping and Laundry if the doors to the Laundry Room were kept locked when there was no staff in the room. The Director said, "Those doors do not lock, they don't have the capability of locking." The surveyor informed the Director of Housekeeping and Laundry of the concern for safety with chemicals being kept on an open shelf in the unlocked Laundry Room.</p> <p>NOTE: The facility's Laundry Room was located west of the double doors of the west wing hall and north up the hall of the hospital side of the facility. Resident #6 & 8 resided on the west wing hall.</p> <p>On 8/29/13 at 2:40 pm, the Administrator and the DON were informed of the safety concern of the chemicals kept unsecured in the unlocked</p> | F 323 | | | |

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

PRINTED: 09/09/2013
FORM APPROVED
OMB NO. 0938-0391

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| F 323 | Continued From page 11 Laundry Room. No information or documentation was provided which resolved the issue. | F 323 | | | |
| F 329 SS=D | 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure residents who received psychopharmacological medications were managed and monitored and residents did not receive anti-psychotic | F 329 | F-329 1. Resident #2's Antipsychotic medication has been discontinued. Resident #4 is receiving dose reductions for the purpose of discontinuing the antipsychotic medication. Resident #1's physician was sent a memo requesting dose reduction. 2. All residents who are taking antipsychotic medication will be reviewed for an appropriate diagnosis. All residents who are on an antianxiety medication will be reviewed for reductions with a physician justification. 3. Staff was inserviced on 9/6/13 and this information will be reviewed again in staff meeting on 9/23/13. Appropriate diagnosis for medication taken will be included in the psychotropic drug committee review. New psychotropic charting forms that can be faxed to the physician for his/her approval will begin immediately. 4. A member of the psychotropic drug committee will do a weekly QA of all residents who are taking antipsychotic medications for the appropriate diagnosis, and for the residents who are taking antianxiety medications for the physician's approval for dose reduction. This will be done weekly until 100% compliance is met for 4 weeks, then monthly until 100% compliance is met for 3 months, then quarterly. Findings of the QA checks will be reported to the administrator at the monthly QA meeting. | 9/20/13 | |

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

PRINTED: 09/09/2013
FORM APPROVED
OMB NO. 0938-0391

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| F 329 | <p>Continued From page 12</p> <p>medications unless the resident's diagnoses met the guidelines for administration of anti-psychotics. This practice created the potential for harm should the medication regimen result in or contribute to an unanticipated decline or newly emerging or worsening symptoms. This was true for 3 of 9 sample residents (#1, 2 and 4). Findings included:</p> <p>1. Resident #2 was admitted to the facility on 12/5/03 with multiple diagnoses including Alzheimer's dementia, depression, and history of glaucoma.</p> <p>Resident #2's 4/23/13 quarterly MDS coded severely impaired cognition and received anti-psychotic medication the past 7 days.</p> <p>Resident #2's 8/13 Active Pharmacy Profile Report (Physician's recapitulation Orders) contained the order 7/10/13, Risperidone (Risperdal) tablet 0.25 mg (milligram) by mouth at bedtime for mood disorder.</p> <p>Resident #2's 8/13 MAR documented the resident was administered Risperidone every day as ordered by the Physician's Orders.</p> <p>On 8/28/13 at 11:25 a.m., the surveyor informed the DON Resident #2 was prescribed Risperidone for the diagnosis of mood disorder and according to F329 Table 1 and the 2014 Nursing Drug Handbook the diagnosis of mood disorder was not an indication for the use of Risperidone. The DON stated, "We are trying to get this medication discontinued. We have done dose reductions."</p> <p>2. Resident #4 was admitted to the facility on</p> | F 329 | | | |

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

PRINTED: 09/09/2013
FORM APPROVED
OMB NO. 0938-0391

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| F 329 | <p>Continued From page 13</p> <p>5/13/07 with multiple diagnoses including dementia, congestive heart failure, and debilitated adult.</p> <p>Resident #4's quarterly 7/16/13 MDS coded severely impaired cognition and received anti-psychotic medication the past 7 days.</p> <p>Resident #4's 8/13 Active Pharmacy Profile Report (Physician's recapitulation Orders) contained the order 7/9/13, Seroquel one tablet 25 mg by mouth each morning for the diagnosis of dementia.</p> <p>Resident #4's 8/13 MAR documented the resident was administered Seroquel every morning as ordered by the Physician's Orders.</p> <p>On 8/27/13 at 11:38 a.m., the surveyor informed the DON Resident #4 was prescribed Seroquel for the diagnosis of dementia and according to F329 Table 1 and the 2014 Nursing Drug Handbook the diagnosis of dementia was not an indication for the use of Seroquel. The DON stated, "We know, we review the residents on anti-psychotic medications on a regular basis and we are doing dose reductions."</p> <p>Federal guidance at F329 Table I specifically identified the diagnoses for administration of anti-psychotic medications. Mood disorder or dementia alone were not identified in Table 1 as appropriate diagnoses for the administration of anti-psychotic medications.</p> <p>The 2014 Nursing Drug Handbook did not identify mood disorder or dementia as indications for use of an anti-psychotic.</p> | F 329 | | | |

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

PRINTED: 09/09/2013
FORM APPROVED
OMB NO. 0938-0391

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| F 329 | <p>Continued From page 14</p> <p>On 8/29/13 at 2:30 p.m., the Administrator was informed Resident #2 and Resident #4 were administered anti-psychotic medications for diagnoses not identified at F329 or in the 2014 Nursing Drug Handbook.</p> <p>On 8/30/13 at approximately 4:45 p.m., the BFS received a fax from the facility. The fax contained a copy of a fax sent to Resident #2's physician on 8/29/13 requesting to discontinue Resident #2's Risperidone as the resident had no increase in behaviors and had done very well with the last graduation dose reduction. The physician discontinued the Risperidone on 8/29/13.</p> <p>3. Resident #1 was admitted to the facility on 8/6/12 and readmitted on 1/1/13 with diagnoses of congestive heart failure, hypertension, seizure disorder, anxiety, and pain.</p> <p>Resident #1's 7/22/13, annual MDS documented in part: -No mental status changes -Received a Antianxiety medication 7 days in the last 7 days</p> <p>Resident #1's August 2013 MAR documented in part: -"Lorazepam TAB, Generic Ativan (1 MG), 1 TAB = 1 MG by mouth (PO) at bedtime for anxiety" and indicated the Lorazepam order was initiated on 10/9/12. The MAR was initialed as given daily during the month of August. -"Lorazepam TAB, Generic Ativan (1 MG), 1 TAB = 1 MG by mouth every four hours as needed for anxiety" and indicated the Lorazepam order was initiated on 2/1/13. The MAR was initialed as given 5 times during the month of August - August 6, 11, 15, 17, and 22, 2013.</p> | F 329 | | |

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

PRINTED: 09/09/2013
FORM APPROVED
OMB NO. 0938-0391

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| F 329 | <p>Continued From page 15</p> <p>Resident #1's August 2013, "Active Pharmacy Profile Report" (Physicians Recapitulation Orders) for Lorazepam was consistant with the MAR.</p> <p>Federal Guidance at F329 V Considerations Specific to Psychopharmacological Medications (Other than Antipsychotics and Sedatives/Hypnotics) read: "During the first year in which a resident is admitted on a psychopharmacological medication (other than an antipsychotic or a sedative/hypnotic), or after the facility has initiated such medication, the facility should attempt to taper the medication during at lease two separate quarters (with at lease one month between the attempts), unless clinically contraindicated.</p> <p>The facility's July 29, 2013 "Psychotropic Drug Meeting Minutes" documented in part: "(Resident #1's name) Lorazepam 1 MG QHS - for anxiety (10-9-12), Lorazepam 0.5 MG- 1 MG Q 4H (hours) PRN - for anxiety (2/1/13) Resident's health issues have increased and so has her anxiety. She is also experiencing paranoia. She becomes very upset over family situations and has poor coping skills. Resident has requested the Lorazepam PRN Q HS dose 13 in February, 2 in March, and 8 in April. The committee recommends no dose reduction at this time."</p> <p>Resident #1 received the anti-anxiety medication, Lorazepam, from 10/9/12 to 8/29/13 without an attempt to taper the medication. No written justification from the physician, that tapering was contraindicated was provided.</p> | F 329 | | | |

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| F 329 | Continued From page 16 On 8/27/13 at 10:55 am, the DON was informed of the concern of no attempts of tapering the Lorazepam or a physician's justification that tapering would be clinically contraindicated for Resident #1. On 8/29/13 at 2:40 pm, the Administrator and DON were informed of the lack of a gradual dose reduction for the Lorazepam for Resident #1. No information or documentation was provided which resolved the issue. | F 329 | | | |
| F 441 SS=E | 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if | F 441 | F-441 On 8/28/13 Laundry Aide #2 sanitized the clean linen table. Laundry staff were inserviced on importance of keeping the clean linen folding table free of soiled or contaminated linens. The clean linen folding table will be cleaned and disinfected after each shift daily. The Director of Housekeeping and Laundry will do a weekly QA to be sure the clean linen folding table is cleaned and disinfected after each shift daily until 100% compliance is met for 4 weeks, then monthly until 100% compliance is met for 3 months, then quarterly. Findings of the QA checks will be reported to the QA committee meeting. | 9/20/13 | |

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

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| F 441 | <p>Continued From page 17</p> <p>direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to maintain a sanitary environment that prevented the spread of disease and infection. Failure to keep dirty mops off the clean table in the facility's Laundry Room created the potential to cause harm due to cross contamination of pathogens of unknown origins and affected all the residents who used the facility's laundry services, including sample residents #1-9. Findings include:</p> <p>On 8/28/13 at 2:30 pm, during the general observation of the facility, dirty floor mops were observed on the clean table of the Laundry Room. Upon the surveyor entering the Laundry Room, Laundry Aide #2 picked up the dirty floor mops from the clean table and placed them in a washing machine. Laundry Aide #2 agreed the table was in the clean area of the Laundry Room. The Director of Housekeeping and Laundry Services was present when the surveyor was interviewing Laundry Aide #2. The Director of Housekeeping and Laundry Services said, "The dirty mops should not be put on the clean table."</p> | F 441 | | |

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

PRINTED: 09/09/2013
FORM APPROVED
OMB NO. 0938-0391

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| F 441 | Continued From page 18 On 8/29/13 at 2:40 pm, the Administrator and DON were informed of the infection control issue with the dirty floor mops on the clean table in the Laundry Room. No information or documentation was provided which resolved the issue. | F 441 | | | |

Bureau of Facility Standards

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001490 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 08/29/2013 |
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| NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE CARE & REHABILITATION | STREET ADDRESS, CITY, STATE, ZIP CODE 1224 8TH STREET RUPERT, ID 83350 |
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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|--------------------|---|---------------|---|--------------------|
| C 000 | <p>16.03.02 INITIAL COMMENTS</p> <p>The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2.</p> <p>The following deficiencies were cited during the State licensure survey of your facility.</p> <p>The surveyors conducting the survey were:</p> <p>Karen Marshall, MS, RD, LD Team Coordinator Karla Gerleve, RN</p> | C 000 | <p>RECEIVED</p> <p>SEP 23 2013</p> <p>FACILITY STANDARDS</p> | |
| C 492 | <p>02.121,05,d,ix Meet Window Requirments</p> <p>ix. Each room shall have a window which can be opened without the use of tools. The window sill must not be higher than three (3) feet above the floor and shall be above grade. The window shall be at least one- eighth (1/8) of the floor area and shall be provided with shades or drapes;</p> <p>This Rule is not met as evidenced by: Based on staff interview, it was determined the facility failed to ensure resident rooms on the West hall had windows that opened. This affected 2 of 9 (#s 6 & 8) sampled residents and all other residents who resided on the West hall, 1 of 3 resident halls. Findings included:</p> <p>On 8/26/13 at 1:45 p.m., the Administrator confirmed the windows in rooms 301 through 317 were non-operable and could not be opened. The Administrator stated the facility would continue to request a waiver of the requirement.</p> | C 492 | <p>C 492 Please renew windows waiver for resident room numbers 301-317.</p> | 9/20/13 |
| C 672 | <p>02.150,03,c Staff Knowledge of Infection Control</p> | C 672 | | |

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| Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Bonnie Sorenson</i> | TITLE <i>Administrator</i> | (X6) DATE 9-20-13 |
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Bureau of Facility Standards

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001490 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 08/29/2013 |
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| C 672 | Continued From page 1 c. Exhibited knowledge by staff in controlling transmission of disease. This Rule is not met as evidenced by: Please refer to F441 in regards to infection control issues in the Laundry Room. | C 672 | C 672 Refer to F441 | 9/20/13 |
| C 779 | 02.200,03,a,i Developed from Nursing Assessment i. Developed from a nursing assessment of the patient's/resident's needs, strengths and weaknesses; This Rule is not met as evidenced by: Please refer to F272 as it related to the assessments of siderails for resident use. | C 779 | C 779 Refer to F272 | 9/20/13 |
| C 784 | 02.200,03,b Resident Needs Identified b. Patient/resident needs shall be recognized by nursing staff and nursing services shall be provided to assure that each patient/resident receives care necessary to meet his total needs. Care shall include, but is not limited to: This Rule is not met as evidenced by: Please refer to F329 as it related to administering anti-psychotic medications without indications for use according to the 2014 Nursing Drug Handbook and federal guidance at F329. Please refer to F329 as it related to not considering a gradual dose reduction for an anti-anxiety medication or a physician's clinical rationale that a dose reduction would be contraindicated. | C 784 | C 784 Refer to F 329 | 9/20/13 |

Bureau of Facility Standards

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| C 790 | Continued From page 2 | C 790 | | |
| 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 F323 as it related to a resident who sustained a fall. In addition, please refer to F323 as it related to unsecured chemicals in the laundry room. | C 790 | C 790 Refer to F 323 | 9/20/13 |
| 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 F281 in regards to providing medications per physicians orders. | C 798 | C 798 Refer to F281 | 9/20/13 |