



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

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

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

**CERTIFIED MAIL: 7012 3050 0001 2125 6119**

September 24, 2014

Shon L. Shuldberg, Administrator  
Ashton Living Center  
700 North Second Street, PO Box 838  
Ashton, ID 83420-0838

Provider #: 135097

Dear Mr. Shuldberg:

On **September 12, 2014**, a Recertification and State Licensure survey was conducted at Ashton Living Center 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 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 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 **October 7, 2014**. Failure to submit an acceptable PoC by **October 7, 2014**, may result in the imposition of civil monetary penalties by **October 27, 2014**.

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

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

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.

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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 **October 17, 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 **October 17, 2014**. A change in the seriousness of the deficiencies on **October 17, 2014**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **October 17, 2014** includes the following:

Denial of payment for new admissions effective **December 12, 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 **March 12, 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 **September 12, 2014** and continue until substantial

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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 **October 7, 2014**. If your request for informal dispute resolution is received after **October 7, 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,

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

DS/dmj  
Enclosures

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

PRINTED: 09/23/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135097</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/12/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>ASHTON LIVING CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>700 NORTH SECOND STREET ASHTON, ID 83420</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS  The following deficiencies were cited during the annual Federal recertification survey of your facility.  The surveyors conducting the survey were Linda Kelly, RN, Team Coordinator, and Judy Atkinson, RN.  The survey team entered the facility on September 8, 2014 and exited the facility on September 12, 2014.  Survey Definitions: ADL = Activities of Daily Living CAA = Care Area Assessment CNA = Certified Nurse Aide DNS = Director of Nursing Services MDS = Minimum Data Set assessment	F 000	Preparation and/or execution of the plan of correction does not constitute admission of agreement the provider of the truth of the facts alleged or conclusions set forth in statement.		
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS  The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.  Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.  Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.	F 164	Specific Resident - LN #5 was talked to about her not protecting privacy. She was very aware of her mistake when spoken to and was embarrassed about her mistake.  Other Residents - All other residents have potential to be affected. Nurses notified immediately per Matrix email to ensure privacy; all staff notified per all staff meeting to ensure privacy.  Systemic Changes - Incorporate into LN and CNA orientation packets how to adequately ensure privacy during all cares, med admin; review privacy in annual resident rights staff meetings; report to QA committee.	RECEIVED OCT - 6 2014 FACILITY STANDARDS	

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

TITLE

(X6) DATE

*Sh. Shilberg* *Administrative* *10/3/14*

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 164	<p>Continued From page 1</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure privacy was maintained when medication was administered via gastrostomy tube for 1 of 1 residents (#11). The failure created the potential for a negative effect on the resident's psychosocial well-being related to the need for privacy. Findings included:</p> <p>On 9/10/14 at 4:10 p.m., Resident #11's mid abdomen and the upper part of her incontinence brief were exposed when LN #5 administered liquid fluoxetine hydrochloride medication (brand name Prozac) via the resident's gastrostomy tube. During the medication administration, the LN did not utilize the privacy curtain or close the door to the room. In addition, the LN did not close the window blind slats which were in the horizontal position. The courtyard was in direct view of the window.</p> <p>At 4:15 p.m., LN #5 was informed of the aforementioned observation. The LN said, "Yes it was" when she acknowledged the resident's mid</p>	F 164	<p>Monitor - DNS to monitor LN admin of g-tube meds 4x weekly for 2 weeks then weekly x4 weeks for correct entering of resident room ensuring privacy. Starting date of audits Oct 6, 2014</p>	Nov 15, 2014

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F 164	Continued From page 2 abdomen and upper part of her incontinence brief were exposed during the medication administration.	F 164	Specific Residents - Resident #7 was observed on three different nebulizer treatments. LN prepared the neb tx, observed resident administration treatment x3 occassions, DR ordered self admin was ok after these observations. Res TARs reflect these changes.  Other Residents - All residents that self administer but we have no others residents that self administer medication at this time in facility.  Systemic changes - Medication Administration Policy and Admin of Meds through a SVN were amended to include IDT approval of self admin of meds by any incoming resident by observation of res safe practice, and also physician order okaying self admin. Nurses were instructed in staff meeting Sept 24 to always consult IDT for approval of self admin of any meds, and Dr must order self admin if he okays it, all of which is necessary to ensure safe administration of medication of optimal benefit of the treatment.  Monitor - DNS will consult admitting LN on all new admits over the next 3 months as to need for approval of self admin of meds or treatments. Observation by LN and okay by Dr will be placed into res orders and will appear on the TAR. All will be reported to the QA Committee. Starting OCT 6, 2014	Nov 1, 2014	
F 176 SS=D	On 9/11/14 at 4:40 p.m., the Administrator and DNS were informed of the issue. The facility did not provide any other information on the issue. 483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE  An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.  This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, resident interview, record review, and policy review, it was determined the facility failed to ensure that residents who wished to self-administer medications were safe to do so. This was true for 1 of 1 residents (#7) with nebulizer treatments during medication pass observations of 1 of 4 LNs (#4). The failure created the potential for Resident #7 to obtain less than optimal benefit from his DuoNeb nebulizer treatments. Findings included:  On 9/9/14 at 12:40 p.m., LN #4 was observed as she set-up Resident #7's SVN (small volume nebulizer) DuoNeb treatment, handed the SVN reservoir with the medication and attached mouthpiece to the resident, turned on the machine, then left the resident's room. The surveyor accompanied the LN as she walked back to the nurses' station. While enroute, the LN				

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F 176	<p>Continued From page 3</p> <p>said the resident was "independent" with the DuoNeb treatments.</p> <p>On 9/9/14 at 12:50 p.m., LN #4 was asked to provide documentation the resident was determined by the IDT to be safe to self-administer the DuoNeb treatments. The LN reviewed the resident's electronic medical record. When the LN did not find the documentation, she said she was "not aware" of any such documentation.</p> <p>On 9/9/14 at 1:00 p.m., LN #4 asked LN #2 for assistance to locate the documentation. LN #2 stated, "Probably not one." LN #2 reviewed the resident's electronic medical record. When LN #2 did not find the documentation she said, "I'm not familiar with such an assessment."</p> <p>Resident #7 was admitted to the facility with multiple diagnoses which included chronic obstructive pulmonary disease (COPD).</p> <p>The resident's admission MDS assessment, dated 7/18/14, coded intact cognition with a BIMS score of 14.</p> <p>The resident's care plan included the problem, "...receives Nebulizer treatment daily and prefers to do them on his own as he was independently doing them at home prior to admit..."</p> <p>The resident's Nursing Facility Admission Orders, dated 7/11/14, included, "Neb TX [treatment]: patient to administer at bedside after nurse set-up following initial assessment by IDT [interdisciplinary team] team."</p> <p>The resident's Prescription Order, dated 7/31/14,</p>	F 176		

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F 176	<p>Continued From page 4</p> <p>documented, "ipratropium-albuterol [DuoNeb] solution for nebulization...1 vial...Four Times A Day...Special Instructions: Ask first, res[ident] may refuse."</p> <p>On 9/10/14 at 12:55 p.m., the DNS provided the facility's Administering Medications policy. The DNS added that there was no assessment or physician orders for Resident #7 to self-administer the DuoNeb treatments.</p> <p>The Administering Medications policy documentation included, "...19. Residents may self-administer their own medications only if the Attending Physician, in conjunction with the Interdisciplinary Care Planning Team, has determined that they have the decision-making capacity to do so safely..."</p> <p>On 9/10/14 at 4:45 p.m., the resident was interviewed. Regarding DuoNeb treatments, the resident said he had been doing them "for years at home." The resident stated, "I do a little bit then put it down and do it later if I need it."</p> <p>On 9/11/14 at 4:40 p.m., the Administrator was informed of the issue. The facility did not provide any other information regarding the issue.</p>	F 176		
F 226 SS=E	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p>	F 226		

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F 226	<p>Continued From page 5</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based record review and staff interviews, it was determined the facility failed to obtain reference checks for 4 of 5 employees reviewed, (Staff A, B, C, D). In addition, the facility failed to verify abuse history with the State Nurse Aide Registry for 2 of 3 CNAs hired (Staff B and C.) This deficient practice created the potential to place residents at risk for abuse, neglect, or misappropriation of property. Findings included:</p> <p>The facility abuse policy and procedures documented the following:</p> <p>" The personnel director, or other person designated by the administrator, will conduct employment background checks and reference checks on persons making application for employment with this facility. Such investigation will be initiated prior to an offer of employment being made."</p> <p>"For any individual applying for a position as a certified nursing assistant, the state nurse aide registry...will be contacted to determine if any findings of abuse, neglect ..."</p> <p>On 9/10/14 at 12:58 PM, five employee personal files were reviewed for reference checks verification with the Human Resources Director (HRD). Staff A, B, C, and D, who were hired on 8/8/14, 6/19/14, 7/21/14 and 6/16/14 respectively, had hand written employment references on their applications, without a date or signature. The HRD said " there should be dates and or signatures on them."</p> <p>Three employee personnel files were reviewed</p>	F 226	<p>Specific Resident - There was no specific residents identified the staff identified A, B, C, D all have State nurse aide Registry verifications and dated reference checks in their file. All employee charts at Ashton Living Center reviewed for State nurse aide registry and dated reference checks all files were found to be in compliance.</p> <p>Other Residents - All Residents have potential to be affected. Human Resource will check CNA registry at time of application to verify CNA license and reference checks will be dated and signed by professional that conducts them at time they are conducted at time of application</p> <p>Systemic Change - HR will conduct State nurse aide Registry verifications at time of application and reference checks will be conduct and date and signed by person conducting reference checks before position is offered a job to be a CNA at Ashton Living Center.</p> <p>Monitor - Administrator will review all new employees files for dated and signed reference checks and State nurse aide Registry for 3 months than quarterly checks to monitor for dated and signed reference checks and State nurse aide Registry being completed before employment has begun. Oct 6, 2014</p>
			Nov 1, 2014

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F 226	Continued From page 6 for the State Nurse Aide Registry check. However Staff B and C, who were employed as CNAs, did not have a copy of the verification check in their personal files on the date requested. The HRD, stated, " I thought I had pulled them before." The HRD provided State Nurse Aide Registry verification which were checked on 9/9/14, with no findings of abuse or neglect.	F 226			
F 241 SS=E	On 9/11/14 at 4:40 PM, the Administrator and DNS were informed of the issues. No further documentation was provided by the facility. <b>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</b>  The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.  This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to: - ensure dining assistance was provided to maintain or enhance each resident's dignity, specifically staff stood while assisting residents to dine: and -ensure respect and privacy of the residents' space when they entered residents' rooms without knocking. Findings included:  1. On 9/11/14 at 5:20 PM, NA (Nurses Aide) #9 was observed during the dinner meal in the main dining room where Residents #2, Resident #5 and Random Resident #14 were sitting at a pink horseshoe table. NA #9 was standing behind the	F 241	Specific Residents - Assisting at pink table with meals reviewed at All staff meeting including sitting while feeding and adjusting the stools as needed; correctly entering a resident room reviewed at All staff meeting by demonstration and discussion, and reviewed of CNA instructional video showing knocking and introducing oneself.  Other Residents - Potential to affect all other residents.  Systemic Changes - Incorporate correct entering of room and protection of res rights/dignity in CNA and LN training checklists, reviewed orientation with dietary manager; Reviewed at annual Res Rights staff meeting.  Monitor - DNS to observe meal times including all three meals 5x weekly for 4 weeks, weekly x 3 months; LNs and dietary staff asked to report individuals violating correct feeding procedure, or entering rooms. Reviewed with QA committee. Will start Oct 6, 2014.	Oct 17, 2014	

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F 241	<p>Continued From page 7</p> <p>table reaching over the plates and giving each resident bites of food. When asked by the surveyor why she was standing, the NA stated, " I am short, [and] these tables don't work well. Is it wrong." NA #9 then sat down to assist the residents with their meal. Within 5 minutes NA #9 was observed standing again.</p> <p>On 9/11/14 at 4:40 PM, the Administrator and DNS were informed of the issues. The DNS stated, " The stools are adjustable." No further information was provided.</p> <p>2. Staff were observed to enter residents' rooms without knocking as follows:</p> <p>a. LN # 1 entered Resident #18's room without knocking on 9/8/14 at 3:05 p.m., during the initial tour. The surveyor knocked on the door before entering the resident's room. The LN knocked on the door before she entered the next resident's room.</p> <p>b. LN #3 entered Resident #4's room without knocking on 9/9/14 at 10:00 a.m.</p> <p>c. CNA #11 entered Resident #4's room without knocking on 9/9/14 at 10:02 a.m.</p> <p>d. CNA #7 entered Resident #2's room without knocking on 9/10/14 at 2:35 p.m. Immediately afterward, the surveyor knocked at the door before entering the resident's room. At 2:40 p.m., the CNA knocked before he entered Resident 9's room.</p> <p>e. LN #5 entered Resident #11's room without knocking on 9/10/14 at 4:10 p.m. At 4:15 p.m., when informed of the observation, the LN acknowledged that she had not knocked.</p> <p>f. CNA #6 entered Resident #11's room without knocking on 9/10/14 at 4:16 p.m. as LN #5 and</p>	F 241		

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F 241	Continued From page 8 the surveyor were leaving the room. When informed of the observation immediately afterward, the CNA acknowledged that he had not knocked. g. LN #2 entered Resident #7's room without knocking on 9/11/14 1:50 p.m. The LN looked directly at the surveyor when the surveyor knocked at the door before entering the resident's room.	F 241		
F 323 SS=E	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 and family interviews, record reviews, and review of Event Reports, the facility failed to ensure a safe environment for 4 of 7 residents (#s 2, 4, 6, and 7) reviewed for falls. The facility failed to: * Ensure wheelchair brakes were locked; * Maintain a Merri-walker in good repair; * Provide adequate supervision; * Consistently implement thirty minute checks as care planned;	F 323		

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F 323	<p>Continued From page 9</p> <ul style="list-style-type: none"> <li>* Use a gait belt as care planned;</li> <li>* Ensure bed rails, a Merri-walker, a lap buddy, and a pommel cushion where assessed to determine if they were safe for individual resident use; and,</li> <li>* Secure a hutch with a glass front and glass and ceramic items inside by 2 residents in the dining room.</li> </ul> <p>The failures created the potential for harm should any resident sustain a major injury from a fall, unsecured furniture, or become entrapped in a device. Findings included:</p> <p>1. Resident #4 was admitted to the facility in August 2013 with multiple diagnoses which included Alzheimer's disease; senile dementia; senile psychosis; anxiety state, and depressive disorder.</p> <p>The resident's annual MDS assessment, dated 8/18/14, documented:</p> <ul style="list-style-type: none"> <li>* Short and long-term memory problems;</li> <li>* Severe cognitive impairment with disorganized thinking;</li> <li>* Extensive assistance of 1 person for bed mobility, transfers, ambulation in room and corridors and on and off the unit, and toileting;</li> <li>* Not steady, only able to stabilize with staff assistance when moving from seated to standing position, walking, and turning around;</li> <li>* Use of a walker;</li> <li>* Frequently incontinent of bowel and bladder;</li> <li>* Two non-injury falls since the previous MDS assessment; and,</li> <li>* Daily use of a chair that prevents rising.</li> </ul> <p>The previous quarterly MDS assessment, dated 5/19/14, documented 1 non-injury fall and daily</p>	F 323	<p>Specific Residents - Since the most recent fall on Sept 7, res #4 has not been placed into the Merri walker, IDT has deemed the wheelchair is safer at this time—FRA updated; checks increased to q15 min; consent updated for PGBs</p> <p>Res #2 Restraint Assessments and Consents for pommel and lap buddy updated, however pommel is DC'd</p> <p>Res #6 PGB restraint assessment updated</p> <p>All Staff Meeting Sept 24 CNAs and LNs will educate all res on admit about the gait belt, what it is and why and how we use it. Reviewed gait belt use in staff meeting, including locking wc brakes before transfer, with demo and discussion, plus video of CNA instructional video Staff instructed to never allow res to refuse use of gait belt, report to LN if they do so and do not ambulate without it correctly placed; nurses and CNAs both document supervised time and scheduled checks to ensure documentation is more complete; staff requested to be more thorough in doc of q30 or q15 min checks—checks will be assigned to one CNA, LN to doc on time they spend with res on these checks as well.</p> <p>Staff meeting review of reporting equipment failure or concerns to Engineering via his steno or report to LN, DNS, or admin if it is not getting fixed.</p> <p>Hutch was secured before surveyors left and showed to surveyors. It continues to be stable.</p>		

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F 323	<p>Continued From page 10</p> <p>use of a chair that prevents rising. And, the quarterly MDS assessment prior to that, dated 2/17/14, documented 1 non-injury fall, 1 non-major injury fall, and daily use of a chair that prevents rising.</p> <p>The resident's Falls CAA, dated 8/18/14, documentation included, "...potential fall risk...declining cognition...decision making is poor...continues to transfers [sic] herself at times...may attempt to go to the bathroom on her own. On 2/21/2014...placed on a Q [every] 2 hour toileting schedule r/t her use of the Merri-walker...Is at risk for tipping over in her Merri-walker as she has had 2 events of this type on 6/23/2014 and 7/23/2014. Both were no injury, but has potential for injury with Merri-walker."</p> <p>The resident's care plan identified the problem, "FALL RISK: (8/23/2014 &amp; 8/24/2014-[resident's name] fell from her Merri-walker d/t [due to] front bar not latching properly)..." Approaches included,</p> <ul style="list-style-type: none"> <li>* "11/21/2013 Observe...frequently and place in supervised area when out of bed."</li> <li>* "12/04/2013...Q 30 minute checks. Assess for any needs..."</li> <li>* "02/20/2014...evaluated by PT [physical therapy]...now using a Merri-walker for safety and prevention of falls while increasing independence."</li> <li>* "02/21/2014 Toilet...every 2 hours and prn [as needed]..."</li> <li>* "06/30/2014 Notify LN and other staff immediately of any s/s [signs or symptoms] of unsafe use of Merri-walker e.g., attempting to climb out, entrapment, etc. Offer to assist her to recliner...by the nurses station, take her to the office to visit...or notify activities for 1:1 [one staff</li> </ul>	F 323	<p>Other Residents - All other residents have ability to be affected</p> <p>Systemic Changes - Restraint Assessment and Consent will be updated quarterly at care plan meetings, or with Change of Condition as deemed necessary by IDT IDT to review in weekly meeting the restraints as any lap buddy, pommel cushion, Merri Walker or other restraint device that as added or is being considered to increase resident safety, while putting into use the least restrictive device available to meet the safety goal, and ensure correct documentation is done. IDT will at that time request PT evaluation of any restraint when one is being considered to ensure it is the safest and least restrictive device available to meet the goal.</p> <p>Environment Services will do monthly equipment safety checks on mobility devices as wheelchairs &amp; walkers, and quarterly safety checks on furniture. Timed checks will be added to chartable tasks on CNA Point of Care online documentation.</p> <p>Lead CNA will review documentation weekly on her office day, reviewing 15 &amp; 30 minute check documentation for completeness and will consult with assigned CNA if incomplete. Medical Records clerk will check 15 and 30 minute checks before filing and report incomplete areas to DNS for correction with assigned CNA.</p> <p>Any gait belt or other device refusals must be reported to DNS and will be referred to OT or PT for correction.</p>	Nov 1, 2014	

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F 323	<p>Continued From page 11 to one resident] or group activities." * "07/02/2014 Monitor for where abouts [sic] to ensure she is not wandering into residents [sic] rooms unattended where she could be a fall risk..." * "08/25/2014 Observe for 72 hours for s/s of head trauma and keep...in line of sight...Merri-walker was repaired and deemed safe..." * "09/03/2014 Toilet...after lunch and place her in a recliner by the nurses station in line of sight and place tabs alarm on her while in the recliner." * "09/03/2014 Obtain PT consult for evaluation today...PT is going to work with her." * "09/08/2014 Discontinue Merri-walker for 72 hours and put...in w/c [wheelchair] while awake in line of sight by staff..."</p> <p>The resident's Physician Order Report, dated 9/1/14 - 9/10/14 included, "02/13/2014 - Open Ended[:] Merry Walker for resident safety, fall prevention..."</p> <p>a) On 9/9/14 at 10:02 a.m., Resident #4 was observed with fading bruises above and below the right eye when LN #3 and CNA #11 aroused her from sleep.</p> <p>The resident was observed either in a w/c or by the nurses station in a recliner with a tab alarm in place on: * 9/9/14 at 11:45 a.m., 1:15 p.m. and 1:45 p.m.; and, * 9/10/14 at 10:30 a.m., 11:45 a.m., 2:00 p.m., 2:30 p.m., 4:30 p.m., and 5:10 p.m.</p> <p>Review of the Event Reports revealed the resident had 9 falls between 2/4/14 and 9/7/14. One fall involved unlocked brakes on her</p>	F 323	<p>Monitor - 4. Lead CNA and med records clerk will report to DNS weekly x8 weeks on scheduled checks. This and Env sup/maint will report to Admin and QA Committee. DNS to observe gait belt use and locked wc brakes for correctness and safety 4x weekly for two weeks, weekly for 4 weeks. Staff meeting review of reporting equipment failure or concerns to Engineering via his steno or report to LN, DNS, or admin if it is not getting fixed. Enviromental. Starting Oct 6, 2014</p> <p>Environment Services will do monthly equipment safety checks on mobility devices as wheelchairs &amp; walkers, and quarterly safety checks on furniture. Starting Oct 6, 2014</p>	

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F 323	Continued From page 12 wheelchair (w/c) and 6 falls involved a Merri-walker.  The Fall Committee documentation included: - 2/5/14: "...New interventions...to care plan to park and dine her [and]...discussed...Merri-walker. Trial attempt will be made." - 3/12/2014: "...uses a merri-walker [sic]...on a Q 30 minute check program...also on a Q 2 hour toileting schedule." - 4/2/14: "...No new fall interventions at this time." * 6/30/14: "...added to fall care plan...Monitor for attempts to climb out of Merri-walker or unsafe use...offer...to sit in recliner...by nurses stations, visits with office staff, or notify activities. Other interventions in place remain appropriate..." - 7/2/2014: "...fall in her merri-walker last month. IDT team has deemed it necessary to continue use of merri-walker as she is much more independent and happier. Staff...to watch for unsafe use of the merri-walker and one on one activities will be provided as necessary....continue 30 minute checks..." * 8/6/14: "...fall in hallway in the merri-walker...on Q 30 minutes checks and Q 2 hour toileting schedule...feel that it is safer and more independent for her to continue to use merri-walker..." - 9/3/14: "...resident benefits more from the merri-walker than putting her in a wheelchair or other modes of transportation....careplan to toilet resident after lunch and place in recliner in sight of staff with a tabs alarm in place for safety." - 9/8/14: "...3 falls since in Merri-walker...still feel...we do not want to take her mobility away...Discussed w/c with lap buddy, but she loves to be able to get around...feel that this would just cause increased agitation. Discussing	F 323			

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F 323	<p>Continued From page 13</p> <p>whether the strap is more hazardous VS [versus] advantage, although strap has not been proven to have been cause of falls...72 hour trial of...w/c or recliner and keeping in line of sight.</p> <p>The resident had six falls while using the Merri-walker. However, the facility did not increase the frequency of supervision. In addition, the facility placed the resident back in the Merri-walker after each the first five falls. Only after the sixth fall in the Merri-walker did the facility consider trial use of a w/c.</p> <p>b) The resident's Fall Risk care plan included every 30 minute checks initiated 12/4/13.</p> <p>Review of the every 30 minute checks for 2/1/14 through 9/7/14 revealed the checks were not consistently documented as done on:</p> <ul style="list-style-type: none"> <li>* 2/7 - 6:00 a.m. through 1:00 p.m.;</li> <li>* 3/3 - 2:00 p.m. and 2:30 p.m.;</li> <li>* Undated - 2:30 p.m. and 3:30 p.m. through 4:30 p.m.;</li> <li>* 7/25 - 2:30 p.m.;</li> <li>* 8/4 - 2:30 p.m.;</li> <li>* 8/15 - 2:30 p.m., 3:30 p.m., 4:00 p.m., and 9:30 p.m.;</li> <li>* 8/16 - 2:30 p.m. through 4:30 p.m.;</li> <li>* 8/17 - 6:30 a.m. through 10:30 a.m.;</li> <li>* 8/23 - 2:30 p.m., 3:30 p.m. through 4:30 p.m., and 9:30 p.m.;</li> <li>* 8/25 - 2:30 p.m. through 3:30 p.m., and 9:30 p.m.;</li> <li>* 8/28 - 2:30 p.m. and 3:30 p.m. through 4:30 p.m.;</li> <li>* 9/6 - 2:30 p.m., 3:00 p.m., 4:00 p.m., and 4:30 p.m.; and,</li> <li>* 9/7 - 12:00 a.m. through 5:00 a.m.</li> </ul>	F 323		

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F 323	<p>Continued From page 14</p> <p>c) Two half side rails were observed in the raised position on Resident #4's bed on: * 9/9/14 at 9:55 a.m., 10:55 a.m., 11:33 a.m., and 3:50 p.m. And, as noted in a) above, the resident's electronic medical record documented the resident used a Merri-walker for ambulation from 2/13/14 through 9/7/14.</p> <p>There was no documented evidence that the side rails or the Merri-walker had been assessed to determine if the resident was safe using them.</p> <p>On 9/11/14 at 11:45 a.m., LN #2 was interviewed. When asked about the 30 minute checks, the LN acknowledged there were blanks in the documentation. When asked if safety assessments were done for the side rails and Merri-walker, the LN confirmed there were none. The LN stated, "We discuss it in care planning meetings." When asked about the resident's fall on 2/4/14, the LN acknowledged that the unlocked w/c rolled out from under the resident. When asked about the resident's multiple falls in the Merri-walker, the LN said the Fall Committee recommended a Merri-walker and after a 72 hour trial the Merri-walker was implemented on 2/13/14. The LN said the Fall Committee felt it was more beneficial for the resident to continue using the Merri-walker than to restrict her mobility. When asked if increased frequency of checks or use of 1:1 staffing when the resident was in the Merri-walker had been considered, the LN referred to the DNS.</p> <p>On 9/11/14 at 2:45 p.m., the DNS and LN #2 were interviewed. When asked if increased frequency of checks or use of 1:1 staffing when the resident was in the Merri-walker was considered, the DNS said they were not.</p>	F 323			

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F 323	<p>Continued From page 15</p> <p>On 9/11/14 at 6:15 p.m., the resident's spouse was interviewed by telephone. When asked about the falls and the Merri-walker, the spouse stated, "She learned how to use an 'easy walker' and she fell a few times because she learned how to open it." The spouse added that the resident "likes to get up and walk by herself."</p> <p>2. Resident #7 was admitted to the facility in July 2014 with multiple diagnoses which included malaise and fatigue, chronic obstructive pulmonary disease, shortness of breath, peripheral neuropathy, and history of falls.</p> <p>The resident's admission MDS assessment, dated 7/18/14, documented:            * Intact cognition with a BIMS score of 14;            * Extensive assistance of 2 staff for transfers;            * Extensive assistance of 1 staff for toileting;            * Range of motion limitation in one upper extremity; and,            * Walker and wheelchair (w/c) use.</p> <p>The resident's Fall CAA, started 7/22/14, documented, "...history of falls prior to admit...He states...2-3 years ago...hit his head on the ice...had nerve irritation and ever since this happened if he turns his head to the left it makes him black out. He states this is what causes him to fall."</p> <p>The resident's care plan included the following problems and approaches:            * "...risk for falls r/t [related to] his decline in functional mobility...falling prior to admission...He states when he turns his head to the left it causes him to pass out at times..." Approaches, all dated 7/12/14, included, "Use gait belt at all times and</p>	F 323		

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F 323	<p>Continued From page 16</p> <p>be cautious to history of syncopal events. He could go down at any time." and, "...REMEMBER TO USE GAIT BELT!"</p> <p>* "...risk for adverse consequences R/T...antidepressant medication..." Approaches included, "Anticipate need for increased assist with...transfers, and mobility. Assist as needed for prevention of falls or injury..."</p> <p>Review of the Event Reports revealed the resident had 2 falls in August 2014.</p> <p>* 8/9/14 at 4:00 a.m. - the resident stated his "R [right] hip just gave out" when a CNA assisted him to transfer from the w/c to the recliner.</p> <p>Note: A Progress Note, dated 8/9/14 at 4:04 a.m., documented the resident, "Refused to let CNA put a gait belt on him..."</p> <p>*8/18/14 at 7:30 a.m. - "Was transferring from bed to w/c. Right hip 'buckled' and staff had to lower him to the fall [sic]." The DNS noted the probable cause of the fall was, "...CNA did not have a gait belt on; res[ident] is a large man, so CNA could not hold him up so lowered him to floor."</p> <p>On 9/11/14 at 2:00 p.m., LN #2 reviewed the resident's medical record and said she did not find any documentation that the resident was educated about the gait belt. In addition, the LN said there was no documented evidence the resident refused to allow staff to use the gait belt after the fall on 8/9/14. The LN acknowledged that the CNA did not follow the care plan when the resident fell on 8/18/14.</p> <p>3. Resident #2 was admitted to the facility in 2006 and readmitted in 2012 with multiple diagnoses which included persistent mental disorder, anxiety and depression, congestive heart failure, oxygen</p>	F 323			

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PRINTED: 09/23/2014  
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  09/12/2014
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 17</p> <p>dependent, peripheral vascular disease, and chronic pain.</p> <p>The resident's annual MDS assessment, dated 6/9/14, documented:</p> <ul style="list-style-type: none"> <li>* Severe cognitive impairment with inattention and disorganized thinking;</li> <li>* Daily occurrence of behavioral symptoms not directed at others;</li> <li>* Extensive assistance of 2 people for bed mobility, transfers, dressing, and toileting;</li> <li>* Frequent bowel and bladder incontinence and on a bladder toileting program;</li> <li>* Facial expressions of pain for 1-2 days in the last 5 days;</li> <li>* Shortness of breath lying flat; and,</li> <li>* No restraints.</li> </ul> <p>The resident's Falls CAA, started 6/12/14, documented, "...uses her feet to get herself around in her w/c [wheelchair]. By doing this she scoots forward at times. Staff need to ensure proper positioning in her w/c at all times with Pommel cushion in place for prevention of falls."</p> <p>The resident's care plan identified falls as a problem on 7/28/14 "and it was decided to place a lap buddy in her w/c to keep her from falling forward out of her chair..." Approaches included, "08/08/2013...pommel cushion in w/c at all times [and] Q [every] 30 minute checks..."</p> <p>The resident's Physician Order Report for 9/1/14 - 9/10/14 included the order, "Place lap buddy &amp; [and] pommel seat cushion while in w/c..." The order was dated 7/29/14.</p> <p>a) The resident was observed in her wheelchair (w/c) with a Pommel seat cushion and a lap</p>	F 323		

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F 323	<p>Continued From page 18</p> <p>buddy in place on 9/10/14 at 10:30 a.m. and 11:45 a.m. and 9/11/14 at 4:30 p.m.</p> <p>The resident was also observed in bed with two 1/2 side rails in the raised position on 9/9/14 at 3:55 p.m. and 9/10/14 at 2:35 p.m.</p> <p>There was no documented evidence in the resident's medical record that the Pommel cushion, the lap buddy, or the side rails had been assessed to determine if the resident was safe using them.</p> <p>b) The resident's Fall Risk care plan included every minute checks initiated in 2013.</p> <p>Review of the 30 minute checks for 7/1/14 through 9/7/14 revealed the checks were not consistently documented as done on:</p> <ul style="list-style-type: none"> <li>* 7/17 - 11:00 p.m. and 11:30 p.m.;</li> <li>* 7/18 - 2:00 p.m. through 9:30 p.m.;</li> <li>* 7/20 - 2:30 p.m., 3:30 p.m. through 4:30 p.m., and 6:30 p.m. through 8:30 p.m.;</li> <li>* 7/21 - 10:30 p.m. through 11:30 p.m.;</li> <li>* 7/30 - 2:00 p.m. through 11:30 p.m.;</li> <li>* 8/1 - 10:30 p.m. through 11:30 p.m.;</li> <li>* 8/3 - 2:30 p.m. and 6:30 through 8:30 p.m.;</li> <li>* 8/4 - 2:30 p.m.;</li> <li>* 8/13 - 2:30 p.m. through 3:30 p.m., 4:30 p.m., and 9:30 p.m.;</li> <li>* 8/16 - 11:30 p.m.;</li> <li>* 8/23 - 2:30 p.m., 4:00 p.m., and 4:30 p.m.; and,</li> <li>* 8/25 - 2:30 p.m. through 4:00 p.m., 6:30 p.m., and 7:00 p.m.</li> </ul> <p>On 9/11/14 at 9:45 a.m., LN #2 was interviewed. When asked about 30 minute checks, the LN acknowledged the checks were not consistently documented as done.</p>	F 323		

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F 323	<p>Continued From page 19</p> <p>On 9/11/14 at 10:20 a.m., LN #2 was asked about safety assessments for the side rails, the Pommel cushion, and the lap buddy, the LN provided a Restraint Assessment for "PGB" which she defined as "partial grab bars." It was dated 2009. The LN also provided one Restraint Assessment which included the Pommel cushion and the lap buddy. This assessment was dated 7/28/14. The LN said the Pommel cushion was started in August 2013, "But we probably did not get a consent or assessment until we realized it when the lap buddy was added 7/28/14." The LN confirmed that none of the Restraint Assessments noted the resident had been assessed to determine if she was safe using the side rails, the Pommel cushion, or the lap buddy.</p> <p>4. Resident #6 was admitted to the facility in 2010 with multiple diagnoses which included vascular dementia with depressed mood, anxiety state, morbid obesity, and gait abnormality.</p> <p>The resident's most recent quarterly MDS assessment, dated 6/27/14, coding included: * Severe cognitive impairment with a BIMS score of 7; * Extensive assistance of 2 people for bed mobility; * Total assistance of 2 people for transfers and toileting; and, * Frequent bowel and bladder incontinence.</p> <p>The resident's care plan included the following problems and approaches: * 7/11/14 - "may be unable to call for assist as needed. A soft touch call light was attempted and he was unable to use..." One approach was, "Check on [resident's name] every 30 minutes</p>	F 323			

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F 323	<p>Continued From page 20 and assess for any needs..."</p> <p>* 10/4/12 - "requires maximum assist with bed mobility." One approach was, "Ensure partial 'grab bars' are up while in bed..."</p> <p>a) Review of the every 30 minute checks for 8/1/14 through 9/10/14 revealed the checks were not consistently documented as done on: * 8/3 - 3:30 p.m. and 4:00 p.m.; * 8/4 - 2:30 p.m., 3:30 p.m., and 4:00 p.m.; * 8/13 - 2:30 p.m., 3:30 p.m., 4:00 p.m., and 7:30 p.m.; * 8/15 - 2:30 p.m., 3:30 p.m., and 4:00 p.m.; * 8/17 - 6:30 a.m. through 7:30 a.m., 8:30 a.m., 9:30 a.m., 10:00 a.m., 11:00 a.m., 11:30 a.m., and 12:30 p.m.; and, * 8/25 - 2:30 p.m. through 4:00 p.m.</p> <p>b) The resident was observed in bed with two 1/2 side rails in the raised position on 9/9/14 at 10:20 a.m., 11:45 a.m. and 3:55 p.m.</p> <p>There was no documented evidence in the resident's medical record that the side rails had been assessed to determine if the resident was safe using them.</p> <p>At 2:45 p.m., the LN #2 provided the resident's 30 minute documentation for 8/1 through 9/10/14. After reviewing the information with the surveyor, the LN acknowledged there were "holes" in the documentation.</p> <p>The LN also provided a SIDE RAIL ASSESSMENT for 12/27/10 which documented the resident had "fluctuations in levels of consciousness or a cognitive deficit," was "able to get in/out of bed," had a "history of falls," had "problems with balance or poor trunk control,"</p>	F 323			

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F 323	<p>Continued From page 21</p> <p>there was "evidence (reason to believe) the resident has (or may have) a desire or reason to get out of bed...forgetful; rises unassisted," and the resident received "medications that would require safety precautions..." However, the 2010 assessment documented there was "NO" risk to the resident if side rails were used. LN #2 acknowledged the assessment did not document that the side rails had been assessed as safe for the resident to use. The LN added that no other side rail assessments had been done.</p> <p>On 9/11/14 at 4:40 p.m., the Administrator and DNS were informed of the issues about falls, assistive devices and restraints, every 30 minute checks and unsecured furniture. The facility did not provide any other information regarding those issues.</p> <p>5. During an environment observation on 9/9/14 at 10:30AM, a glass door hutch which contained many ceramic and glass items was noted in the far right corner of the dining room. The hutch was behind a dining table that was set for 2 residents to dine and was not secured to the wall. Additionally, the top of the hutch was not attached to the bottom half causing the hutch to sway back and forth when touched.</p> <p>During an interview with the CDM/Dietary Supervisor on 9/9/14 at 10:40 AM, the CDM stated the hutch "needs to be stabilized, [it's] not good." During the interview the CDM began to move the hutch back and forth, when the bottom door opened and numerous ceramic plates fell out onto the floor and broke into pieces. The CDM then stated, "I will get Maintenance on that right now."</p>	F 323		

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F 323	Continued From page 22 On 9/9/14 at 4:15 PM, the Administrator and DNS were informed of the issue. No further information was provided.	F 323			
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS  The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.  This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to clarify conflicting physician's orders for oxygen (O2) for 2 of 5 residents (#s 6 and 7) reviewed for specialty care. Failure to clarify the O2 orders with the physician created the potential for an increase in respiratory problems if the residents' respiratory needs were not met. Findings included:  1. Resident #6 was admitted to the facility in 2010 with multiple diagnoses which included vascular dementia with depressed mood, anxiety state, morbid obesity, and hypoxemia (deficient oxygenation of the blood).  The resident's most recent quarterly MDS	F 328	Specific Residents - Res #6 orders updated to read "Oxygen flow rate @ 2L/NC to keep sats greater than 88%." , physician has signed. Other O2 orders DC'd. Res #7 Orders updated to read "Oxygen 2-3 lpm, adjust prn to keep sats greater than 90%." Physician signed. Other O2 orders DC'd. Nursing staff meeting 9-24 nurses instructed to double check O2 orders as they were put into Matrix and DC all previous orders, leaving only the most current orders.  Other Residents - All other residents have the potential to be affected.  Systemic Changes - MDS coordinator will check O2 orders on admit and quarterly for duplicate orders and update as needed. O2 orders to be reviewed in quarterly care plans and updated as needed to most current orders.  Monitor - 4. DNS to review all res on O2 for more than one O2 order. DNS will review new orders weekly and update as needed to most current O2 order. Starting Oct 6, 2014.	Oct 15, 2014	

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F 328	<p>Continued From page 23 assessment, dated 6/27/14, documented: * Severe cognitive impairment with a BIMS score of 7; * Extensive and/or total assistance for all ADLs; and, * O2 use.</p> <p>The resident's care plan included the following problems and approaches: * 10/4/12 - "Pickwickian Syndrome...people...severely overweight fail to breathe rapidly enough or deep enough resulting in low blood oxygen levels and may cause obstructive sleep apnea..." Approaches included, "Administer oxygen at 2-3L/NC to keep sats &gt; 90% [2 to 3 liters per nasal cannula to keep oxygen saturation levels greater than 90 percent]..." and "Monitor oxygen saturation...BID and prn [twice a day and as needed]."</p> <p>The resident's Physician Order Report for 9/1/14 - 9/10/14 included 3 different orders, given in 2012, for O2. The orders were: * 3/16/12 - Check O2 sats BID, "Special Instructions: If...less than 88 %, titrate O2 to keep over 92%..." * 3/16/12 - Oxygen at 2-3 liters "...Every Shift; Day, Evening, Night." * 3/19/12 - "Oxygen: give at 3L/pm [3 liters per minute] via N.C. [nasal cannula] continuously."</p> <p>The resident's TARs for 8/1/14 - 8/31/14 and 9/1/14 - 9/9/14 contained the 3/19/12 order for O2 at 2-3 liters every shift. Again, 3/19/12 was the most recent O2 order.</p> <p>The resident was observed with O2 via a NC as follows: * 9/9/14 at 10:20 a.m., 10:55 a.m., and 11:35 a.m.</p>	F 328		

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F 328	<p>Continued From page 24</p> <ul style="list-style-type: none"> <li>- O2 at 2L while in bed;</li> <li>* 9/9/14 at 12:05 p.m. - O2 at 2L while eating in the dining room;</li> <li>* 9/10/14 at 10:30 a.m. and 11:05 a.m. - O2 at 2L while in recliner in lobby.</li> </ul> <p>On 9/10/14 at 11:10 a.m., when asked what the resident's O2 liter flow rate was supposed to be, LN #3 stated, "Two liters." When asked what liter flow rate was ordered, the LN stated, "Two to 3 liters." When informed there was more than one order for O2, the LN reviewed the resident's physician's orders and stated, "There are actually 3 orders for oxygen. Guess we need to clarify that. He's always done well on 2 [liters]." LN #3 said she would contact the physician right away to request clarification.</p> <p>2. Resident #7 was admitted to the facility in July 2014 with multiple diagnoses which included chronic obstructive pulmonary disease (COPD) and shortness of breath.</p> <p>The resident's admission MDS assessment, dated 7/18/14, documented:</p> <ul style="list-style-type: none"> <li>* Intact cognition with a BIMS score of 14;</li> <li>* Extensive assistance for most ADLs; and,</li> <li>* Oxygen use.</li> </ul> <p>The resident's care plan identified the problem, "...wear oxygen continuous [sic] to keep sats &gt; 90% r/t [oxygen saturation levels greater than 90 percent related to]...COPD." Approaches included, "07/11/2014 Administer oxygen at 3L/NC [3 liters per nasal cannula] to keep sats &gt; 90%..."</p> <p>The resident's Physician Order Report for 9/1/14 - 9/11/14 included the following O2 orders:</p>	F 328		

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F 328	Continued From page 25 * 7/22/14 - "Oxygen at 3L to keep sats > 90%." * 8/21/14 - "Oxygen to keep sats greater than 90%."  The resident was observed with O2 via a NC as follows: * 9/10/14 at 4:50 p.m. - O2 between 1.5 and 2L while in recliner by bed; * 9/10/14 at 5:15 p.m. - O2 at 2L while in wheelchair in dining room;  On 9/11/14 at 1:30 p.m., when asked what the resident's O2 liter flow rate was supposed to be, LN #12 stated, "Probably two. That's what it usually is." When asked what liter flow rate was ordered, the LN reviewed the resident's orders and said she found "two different O2 orders" and that the 8/21/14 order "doesn't say how many liters." The LN stated, "We probably need to get clarification." The LN said she would contact the physician right away.  On 9/11/14 at 1:45 p.m., LN #2 accompanied the surveyor to the resident's room. The resident was in his recliner with the O2 NC in place. When asked to read the liter flow rate setting on the O2 concentrator, LN #2 said, "Between 1.5 and 2."	F 328			
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE  The facility must ensure that it is free of medication error rates of five percent or greater.  This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was	F 332			

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F 332	<p>Continued From page 26</p> <p>determined that 2 of 3 licensed nurses failed to flush a random resident's (#11's) feeding tube in between and/or after administration of medications. The failure created the potential for the resident to receive less than optimum benefit from the medications. Findings include:</p> <p>Note: Regarding the administration of medications via a feeding tube, CMS Letter 13-02-NH, stated, "...The procedures must reflect current standards of practice, including but not limited to...administering drugs separately...and flushing the feeding tube before, between, and after drug administration..."</p> <p>1. On 9/9/14 at 1:05 p.m., LN #3 was observed as she poured Mapap (liquid acetaminophen) for Resident #11. The LN flushed the resident's feeding tube with distilled water then administered the Mapap. However, the LN did not flush the feeding tube after the medication administration. The LN was stopped just before she started the resident's Jevity tube feeding. When asked if she had flushed after the medication administration, the LN stated, "Oh no, I didn't."</p> <p>2. On 9/11/14 at 10:30 a.m., LN #12 was observed as she mixed 4 liquid medications (Mapap, Vitamin D supplement, Colace, and Loratadine) together in cranberry juice then administered the mixture of medications and juice to Resident #11 via the resident's feeding tube.</p> <p>At 10:45 a.m., LN #12 was informed of the aforementioned CMS letter and asked about the 4 medications administered together via the resident's feeding tube. The LN confirmed the medications were administer together and stated, "I was not aware of that."</p>	F 332	<p>Specific Residents - Nurses verbally notified immediately of correct med admin via enteral tube, requested that info be passed on in shift change report. Correct med admin procedure reviewed in nursing staff meeting 9-24-14: Nurses are instructed that tube must be flush with water before med. Never start a feeding until the last flush is done. Adminstrating Meds through and Enternal Tube policy and CMS letter 13-02-NH reposted at nurses' computer for frequent nurse review as needed.</p> <p>Other Residents - May affect one active and all future residents with any gastric tube for med admin and/or feeding.</p> <p>Systemic Changes - Procedure for Administering Medications through an Enteral Tube has been updated to meet regulations as outlined in CMS Letter 13-02-NH.</p> <p>Monitoring - DNS to monitor LN admin of g-tube meds 4x weekly for 2 weeks, weekly x4 weeks observing every day shift and evening shift for correct procedure. Starting Oct 6, 2014.</p>

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 332	Continued From page 27	F 332	Specific Residents - Med areas were checked by nurses on Oct 15, 2014 all expired meds removed. Correct procedure reviewed in nurses staff meeting Sept 24 including wasting of used fentanyl patch in biohazard container in med room, and	Nov 1, 2014	
F 431 SS=E	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	F 431	cosigning of the waste by 2 nurses; reviewed outdated meds in med and tx carts and med med room and how they must be removed from these to areas to ensure they are never used on a resident after the outdate; reviewed placing DC'd meds on res and inactive res with the control count sheet affixed into the lockup in the tx cart for disposal by the pharmacist and the DNS; reviewed dating a multidose med vial when it is opened so it will be discarded in a timely manner complaint with pharmacy recommendations for that med.  Other Residents - All other residents have potential to be affected.  Systemic changes - Controlled Substances policy updated with information in CMS Letter 13-02 NH regarding safe fentanyl patch disposal, and cosigning by 2 LNs on controlled substance record when a fentanyl patch is removed; same policy updated to include waste of DC'd controlled substances on active residents; new schedule created for quarterly review by LN of every area that contains meds or other items that have outdates, that need to be disposed of correctly and timely to ensure they are never used on a resident after outdate.		

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F 431	<p>Continued From page 28 be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and policy and procedure (P&amp;P) review, it was determined the facility failed to ensure: * Two licensed nurses witnessed and signed when used fentanyl patches were wasted for 4 or 4 residents (#s 4, 5, 16, and 17) reviewed for fentanyl patch use; and, * Outdated medications, biologicals, and discontinued medications in the treatment cart and the medication room medication refrigerator were not available for resident use. These failures created the potential for diversion of and/or accidental exposure to the remaining amount of controlled pain medication in used fentanyl patches for Resident #'s 4, 5, 16, and 17, and for the diversion of Resident #15's discontinued lorazepam; reduced efficacy of Resident #2's outdated Clotrimazole cream and an outdated bottle of hydrogen peroxide for floor stock; and, oxidation and degradation which may affect potency of opened vials of Aplisol (used to screen for tuberculosis). Findings included:</p> <p>1. Note: Informational Letter, Reference: S&amp;C: 13-02 NH, stated, "Fentanyl transdermal patches are a controlled substance commonly used in nursing homes for pain medication. These patches present a unique situation given the multiple boxed warnings, the potential for abuse, misuse and diversion, and the substantial amount of fentanyl remaining in the patch after use. The facility's policies must address safe and secure storage, limited access and reconciliation of</p>	F 431	<p>Monitor - DNS to observe correct and safe disposal of used fentanyl patch and to observe cosigning by 2 LNs weekly x4, then monthly x4; DNS and LN together will follow the newly created quarterly schedule for reviewing several areas having meds or supplies with outdates, documentation to be completed for the first quarter and reported to QA committee, two LN's will complete subsequent quarterly reviews. Starting Oct 6, 2014</p>	

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F 431	<p>Continued From page 29</p> <p>controlled substances in order to minimize loss or diversion, and provide for safe handling, distribution and disposition of the medications... The remaining fentanyl in a used patch is a potential vehicle of abuse and accidental overdose and warrants implementation of adequate disposal policies... Staff should dispose of fentanyl patches in the same manner as wasting of any other controlled substances, particularly because the active ingredient is still accessible. Wasting must involve a secure and safe method, so diversion and/or accidental exposure are minimized..."</p> <p>On 9/9/14 at 10:15 a.m., during a medication pass observation with LN #3, Resident #4's e-MAR was briefly reviewed regarding fentanyl patch use. The review revealed the resident received 1 fentanyl 25 microgram patch every 3 days for pain control. However, there was no documentation in the resident's e-MAR that used fentanyl patches were wasted and witnessed by 2 LNs.</p> <p>On 9/10/14 at 12:20 p.m., the DNS was asked to provide the facility's policy and procedures (P&amp;P) regarding controlled medication, including used fentanyl patches.</p> <p>On 9/10/14 at 1:00 p.m., the DNS provided a Controlled Substances P&amp;P which documented, "14. When a fentanyl patch is removed...it must be correctly destroyed to prevent diversion or other abuse or accident involving the medication remaining in the patch. When any medication patch is removed from the resident, it will be placed in a red biohazard container." The P&amp;P did not address 2 LNs to witness and sign for the wasting of used fentanyl patches. The DNS was</p>	F 431			

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F 431	<p>Continued From page 30</p> <p>asked to provide a list of residents who received fentanyl patches.</p> <p>On 9/10/14 at 1:30 p.m., the DNS provided the requested list which documented Resident #s 4, 5, 16, and 17 received fentanyl patches. When asked if the wasting of used fentanyl patches was witnessed and signed by 2 LNs, the DNS stated "No. They are changed at 5:00 a.m. when only 1 LN is here." The DNS added, "We will be changing that."</p> <p>2. On 9/10/14 at 12:00 p.m., during inspection of the Treatment Cart with LN #4 and the DNS in attendance, the following outdated and discontinued (DC'd) medications were found:</p> <ul style="list-style-type: none"> <li>* One floor stock 16 fluid ounce bottle of hydrogen peroxide expired 5/14;</li> <li>* One 30 gram tube of Clotrimazole cream 1% for Resident #2 expired 6/14; and,</li> <li>* Six 10 milliliter vials of injectable lorazepam (generic Ativan) 2 milligrams/milliliter for Resident #15 expired 11/13. Wrapped around the bag of lorazepam was documentation that the medication was DC'd "7/5/12."</li> </ul> <p>Regarding the expired and DC'd lorazepam, the DNS pointed to the 7/5/12 DC date and stated, "It should have left [the facility] then." The DNS added, "I will get rid of the lorazepam tomorrow when the pharmacist is here."</p> <p>LN #4 said she would dispose of the other outdated medications.</p> <p>On 9/10/14 at 12:20 p.m., the DNS was provided the facility's policy and procedures (P&amp;P) regarding controlled medication.</p>	F 431		

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F 431	<p>Continued From page 31</p> <p>On 9/10/14 at 1:00 p.m., the DNS provided a Controlled Substances P&amp;P which documented, "12. When a resident or patient is transferred or discharged from the facility, controlled medications may not be given to the resident to take with them and may not be returned to the pharmacy, but must be destroyed in accordance with established policies. 13. The medication and the control record will be placed together in the locked box in the treatment cart for disposal by the pharmacist and the DNS. The pharmacist will ensure disposal in a way compliant with all state and federal regulations. The DNS will file the control records and keep..."</p> <p>The policy did not address controlled medications that were DC'd for a resident still in the facility.</p> <p>3. On 9/10/14 at 12:30 p.m., during inspection of the medication refrigerator in the medication room with LN #4 in attendance, 2 opened vials of Aplisol, (Tuberculin Purified Protein Derivative, Diluted) did not have an open date. The LN confirmed the absence of an open date on each Aplisol vial and said she did not know when they were opened. At that time, the DNS joined the inspection and instructed the LN to dispose of the 2 vials.</p> <p>The Aplisol package information documented, "Vials in use more than 30 days should be discarded due to possible oxidation and degradation which may affect potency."</p> <p>On 9/11/14 at 4:40 p.m., the Administrator and DNS were informed of the issues. The facility did not provide any other information regarding the issues.</p>	F 431			

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F 441 F 441 SS=D	Continued From page 32 483.65 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 direct contact will transmit the disease. (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.  (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441 F 441	Specific Residents - Hand Hygiene policy verbally reviewed in All Staff Meeting Sept 24, 2014. also watched CNA training video regarding hand hygiene.  Other Residents- Potential to affect all other residents.  Systemic Changes - Regular Schedule every other month of hand hygiene review in staff meetings  Monitor - DNS to randomly observe hand hygiene practices of CNAs x4 weekly for 4 weeks, then x1 weekly for 4 weeks. LNs, CNAs, and dietary staff asked to report any hand hygiene policy violations to DNS so individuals can be corrected as needed. Starting Oct 6, 2014	Oct 17, 2014	

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F 441	Continued From page 33  This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure infection control measures were consistently implemented. This was true for 1 of 10 sample residents (#2). Failure to consistently implement hand hygiene after direct contact with residents placed residents at risk for infections. Findings included:  1. On 9/9/14 at 4:00 PM, CNA #13 was observed in the process of providing incontinence care for Residents #2. CNA #14 arrived at the same time as the surveyor and she assisted CNA #13. Upon completion of the incontinence care, CNA #13 removed her gloves. However, CNA #13 did not perform any kind of hand hygiene before she applied a gait belt on the resident and assisted CNA #14 to transfer the resident from bed to wheelchair (w/c), straightened the bed linens, moved the call light, opened the drawers to the bedside table, chest of drawers and below the closet, then applied a lap buddy to the resident's w/c. Only after that did CNA #13 wash her hands.  On 9/9/14 at 4:15 PM, the surveyor asked CNA #13 about the lack of hand hygiene after the incontinence care. The CNA stated, "Oh that's right. But I removed my gloves, I didn't do it with my gloves on."  On 9/11/14 at 4:40 p.m., the Administrator and DNS were informed related to the observation. No further information was provided.  2. On 9/10/14 at 2:35 p.m., CNA #7 was observed to uncover Resident #2's lower extremities per	F 441		

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F 441	<p>Continued From page 34</p> <p>the surveyor's request and reposition the resident's feet then leave the resident's room without performing any type of hand hygiene.</p> <p>At 2:40 p.m., CNA #7 was about to enter another resident's room when he was stopped and asked if he had cleansed his hands. The CNA stated, "I didn't. I'll go get some hand sanitizer now." The CNA left and returned moments later still rubbing his hands together. He said he had used hand sanitizer.</p> <p>On 9/11/14 at 4:40 p.m., the Administrator and DNS were informed of the infection control issues. The facility did not provide any other information on the issues.</p>	F 441			

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NAME OF PROVIDER OR SUPPLIER  
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STREET ADDRESS, CITY, STATE, ZIP CODE  
**700 NORTH SECOND STREET  
ASHTON, ID 83420**

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C 000	<p><b>16.03.02 INITIAL COMMENTS</b></p> <p>The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2.</p> <p>The following deficiencies were cited during the State licensure survey of your facility.</p> <p>The surveyors conducting the survey were: Linda Kelly, RN, Team Coordinator, and Judy Atkinson, RN.</p>	C 000	<p style="text-align: center;">RECEIVED OCT - 6 2014 FACILITY STANDARDS</p>		
C 125	<p><b>02.100,03,c,ix Treated with Respect/Dignity</b></p> <p>ix. Is treated with consideration, respect and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs;</p> <p>This Rule is not met as evidenced by: Please refer to F241 as related to dining with dignity and knocking before entering residents' rooms, and F164 for privacy during personal care.</p>	C 125		Refer to F164 and F241	Nov 15, 2014
C 191	<p><b>02.105,05 APPLICABLE IDAHO &amp; FEDERAL LAWS</b></p> <p>05. Applicable Idaho and Federal Laws. Applicable Idaho and federal laws shall be observed in relation to employment of any individual.</p> <p>This Rule is not met as evidenced by: Refer to F226 as it related to reference checks for prospective employees and CNA registry status checks for newly hired CNAs.</p>	C 191		Refer to F226	Nov 1, 2014

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

*[Handwritten Signature]*

TITLE

*Administrator*

(X6) DATE

*10/3/14*

Bureau of Facility Standards

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C 670	Continued From page 1	C 670		
C 670	02.150,03,a Aseptic/Isolation Techniques  a. Applied aseptic or isolation techniques by staff. This Rule is not met as evidenced by: Please refer to F441 as related to hand hygiene after personal cares.	C 670	Refer to F441	Oct 17, 2014
C 788	02.200,03,b,iv Medications, Diet, Treatments as Ordered  iv. Delivery of medications, diet and treatments as ordered by the attending physician, dentist or nurse practitioner; This Rule is not met as evidenced by: Refer to F328 as it related to orders for oxygen.	C 788	Refer to F328	Oct 15, 2014
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: Refer to F323 as it related to residents' falls, inadequate supervision, and unsecured furniture.	C 790	Refer to F323	Nov 1, 2014
C 792	02.200,03,b,viii Comfortable Environment  viii. Maintenance of a comfortable environment free from soiled linens, beds or clothing, inappropriate application of restraints and any other factors which interfere with the proper care of the patients/residents; This Rule is not met as evidenced by: Refer to F323 as it related to devices not assessed for safe use by residents.	C 792	Refer to F323	Nov 1, 2014

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C 798	Continued From page 2	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: Refer to F332 as it related to medication errors.	C 798	Refer to F332	Nov 15, 2014
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: Refer to F431 as it related to expired medications.	C 821	Refer to F431	Nov 1, 2014
C 823	02.201,01,d Review Narcotic and Dangerous Med Logs  d. Reviewing the narcotic and dangerous drug records at least every thirty (30) days and certifying to the administrator that this inventory is correct.  This Rule is not met as evidenced by:	C 823	Refer to 431	Nov 1, 2014

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C 823	Continued From page 3 Refer to F431 as it related to controlled medications.	C 823		
C 835	02.201,02,i Meds in Possession of Resident Limitations  i. No medication shall be in the possession of the patient/resident unless specifically ordered by the physician on the patient's/resident's medical record, and in no case shall exceed two (2) units of dosage. All such medications shall be individually packaged by the pharmacist in units of dose, labeled with the patient's/resident's name, unit of dose, and date of distribution. The charge nurse shall maintain an inventory of these drugs on the patient's/resident's medical record.  This Rule is not met as evidenced by: Please refer to F176 as it related to Self Administration of Drugs	C 835	Refer to F176	Nov 1, 2014