



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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BUREAU OF FACILITY STANDARDS
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CERTIFIED MAIL: 7012 1010 0002 0836 2175

October 8, 2013

Darwin G. Royeca, Administrator
Lincoln County Care Center
511 East Fourth Street, PO Box 830
Shoshone, ID 83352-1502

Provider #: 135056

RE: SEPTEMBER 27, 2013, RECERTIFICATION AND STATE LICENSURE SURVEY
REPORT COVER LETTER

Dear Mr. Royeca:

On **September 27, 2013**, a Recertification and State Licensure survey was conducted at Lincoln County Care Center by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be one that comprises a pattern that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies, and a similar State Form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 3). **Please provide ONLY ONE completion date for each federal and state tag in column (X5) Completion Date, to signify when you allege that each tag will be back**

in compliance. WAIVER RENEWALS MAY BE REQUESTED ON THE PLAN OF CORRECTION. After each deficiency has been answered and dated, the administrator should 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 **October 21, 2013**. Failure to submit an acceptable PoC by **October 21, 2013**, may result in the imposition of civil monetary penalties by **November 12, 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

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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 **November 1, 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 **November 1, 2013**. A change in the seriousness of the deficiencies on **November 1, 2013**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **November 1, 2013** includes the following:

Denial of payment for new admissions effective **December 27, 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 27, 2014**, if substantial compliance is not achieved by that time.

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

If you believe these deficiencies have been corrected, you may contact Loretta Todd, R.N. or Lorene Kayser, L.S.W., Q.M.R.P., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0036; phone number: (208) 334-6626; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

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If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **September 27, 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:

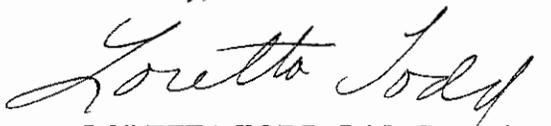
- BFS Letters (06/30/11)

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

This request must be received by **October 21, 2013**. If your request for informal dispute resolution is received after **October 21, 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,


LORETTA TODD, R.N., Supervisor
Long Term Care

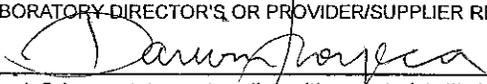
LT/dmj
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135056	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/27/2013
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NAME OF PROVIDER OR SUPPLIER LINCOLN COUNTY CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 511 EAST FOURTH STREET SHOSHONE, ID 83352
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the annual federal recertification survey of your facility.</p> <p>The surveyors conducting the survey were: Arnold Rosling, RN, BSN, QMRP, Team Coordinator Sherri Case, LSW Becky Thomas, RN</p> <p>Survey Definitions: MDS = Minimum Data Set assessment CAA = Care Area Assessment DON = Director of Nursing LN = Licensed Nurse CNA = Certified Nurse Aide ADL = Activities of Daily Living MAR = Medication Administration Record RNA = Restorative Nurse aide RSD = Resident Service Director RD = Registered Dietitian</p>	F 000		
F 241 SS=E	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and observation, it was determined the facility failed to ensure that residents were treated with dignity and respect during their dining experience when they were not offered a cloth napkin. This was true for 6 of 6</p>	F 241	<p>F 241</p> <p>DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility will ensure that residents are treated with dignity and respect during their dining experience by offering a choice of cloth napkin and clothing protector.</p> <p>All residents have the potential to be affected by this practice.</p>	<p>RECEIVED OCT 21 2013 FACILITY STANDARDS</p> <p>10/18/13</p>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 10/18/13
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 241	<p>Continued From page 1</p> <p>sampled residents (#s 1-6) and all other residents observed during meals. Findings include:</p> <p>During the mid-day meal observation on 9/23/13 at 11:50 a.m., no less than 15 residents were observed to be in the dining room. CNAs and LNs were observed to be assisting the residents to put on clothing protectors. At that time Resident #12 was asked if she was offered a cloth napkin instead of the clothing protector. Resident #12 stated staff offered everyone a clothing protector. LN #3 was observed to place a clothing protector on a resident. LN #3 was asked if cloth napkins were used and stated the residents preferred to have clothing protectors.</p> <p>On 9/24/13 at 8:20 a.m. during the morning meal staff were observed to assist residents with clothing protectors, however, cloth napkins were not offered.</p> <p>During the mid-day meal on 9/25/13 at noon, 2 CNAs were observed in the dining room. One CNA was offering cloth napkins and the other was offering clothing protectors. Two of the residents chose to have the cloth napkins instead of the clothing protectors.</p> <p>During the evening meal, on 9/25/13 at 6:00 p.m., LN #3 was observed to place a clothing protector on Resident #13 without asking if the resident would like the clothing protector. LN #3 then placed a clothing protector on Resident #3 without asking if the resident would like a cloth napkin or the clothing protector.</p> <p>On 9/26/13 at 9:00 a.m. the RSD stated the facility was attempting to change the "culture" by remodeling the dining room. The RSD said the</p>	F 241	<p>Staff were in serviced on Federal tag and deficient practice and facility policy. All staff assisting in the dining room for meals will offer residents a choice of cloth napkin and clothing protector.</p> <p>Dining room audit for at least daily for two weeks was started on October 16, 2013. One meal a day will be audited so as to include all meals and compliance.</p> <p>Please See Exhibit A.</p> <p>Department heads will also be assigned to complete one dining room audit weekly X 4 and then every two weeks X 4 and then monthly X 3. Department head will sign the completed audit sheet and turn into the D.N.S. for review.</p> <p>Audits will start on October 16, 2013.</p> <p>All audits will be reviewed at monthly CQI meeting.</p>	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/04/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135056	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/27/2013
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F 241	Continued From page 2 staff should have offered the residents a choice of a clothing protector or a napkin. The RSD stated most residents chose the clothing protector, staff knew the residents preference and that is why the cloth napkin was not offered. The RSD clarified by stating the staff should still offer the cloth napkin. On 9/26/13 at 1:15 p.m. the Administrator asked about the dining room observations. The Administrator was informed the residents were not offered a cloth napkin. The Administrator stated staff were to always offer a cloth napkin to the residents.	F 241			
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to accommodate a resident by preventing the morning sunlight from shining in the window and disrupting breakfast. This was true for 1 of 8 (#8) sampled residents. This had the potential to harm the resident because she was not able to eat her food due to the distraction. Findings include: On 9/24/13 from 8:20 to 8:30 a.m., Resident #8	F 246	F 246 REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES The facility will ensure to provide reasonable accommodations of individual needs and preferences by preventing the morning sunlight from shining in the window to disrupt breakfast. Resident # 8 was moved to another table on September 24, 2013 where the sunlight will not bother her anymore. All residents have the potential to be affected by this practice. Staff were in serviced on Federal tag and deficient practice and facility policy. All staff assisting residents in dining room for meals will accommodate resident's needs by blocking the sun using the cloth panels or by moving the resident to another table if needed.	10/18/13	

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F 246	Continued From page 3 was observed sitting in her wheelchair at a long dining table. The resident was eating her breakfast. The morning was cloudy with intermittent sunlight. When the sun came out from behind the cloud it would shine directly on the resident's face. The sun was coming in from small windows that were located near the ceiling in the activity area, which was adjacent to the dining room. These windows went the length of the outside wall. Two other tables at the facility were seen to be affected by the sun but these residents could make their needs known. The residents complained and the staff put folding cloth panels by the tables to block the sunlight. Resident #8 did not get her needs accommodated and was observed either to not eat or squint when the sun shined in her eyes.	F 246	Dining room audit for at least daily for two weeks was started on October 16, 2013. One meal a day will be audited so as to include all meals and compliance. Please See Exhibit B . Department heads will also be assigned to complete one dining room audit weekly X 4 and then every two weeks X 4 and then monthly X 3. Department head will sign the completed audit sheet and turn into the D.N.S. for review.	
F 280 SS=E	On 9/26/13 at 9:30 a.m. the DON was interviewed and indicated that someone should have moved the resident to a different table so the sun did disrupt her breakfast. 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs,	F 280	All audits will be reviewed at monthly CQI meeting. Audits will start on October 16, 2013. F 280 RIGHT TO PARTICIPATE PLANNING CARE – REVISE CP The facility will ensure that a resident's care plan will be reviewed and revised after there were changes in the resident's status.	10/18/13

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F 280	<p>Continued From page 4</p> <p>and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure residents' care plans were reviewed and revised after there were changes in the residents' status. This was true for 7 of 10 sampled residents (#s 1, 2, 3, 5, 6, 7 and 8). This had the potential to result in harm if residents did not receive appropriate care due to lack of direction in the care plan. Findings included:</p> <p>1. Resident #1 was admitted to the facility on 9/20/12 with diagnoses of bronchitis, prolonged depression, weight loss, CVA (cerebrovascular accident), chronic pain, delay in development and dementia with behaviors.</p> <p>Resident #1's care plan for physical functioning and mobility impairment, dated 2/26/13, documented the resident was to wear a special hand splint due to contractures of the right hand. Resident #1 was observed without a right hand splint on 9/23/13 at 2:15 PM, and on 9/24/13 at 8:20 AM, 9:15 AM, 10:00 AM, and 11:00 AM.</p> <p>Resident #1's OT (Occupational Therapy) assessment, dated 4/10/13, documented the brace was not needed and recommended a</p>	F 280	<p>Care plans for resident #s 1, 2, 3, 5, 6, 7 and 8 were reviewed and revised.</p> <p>Resident # 1's care plan was reviewed and updated on October 1, 2013 to take out the use of hand splint as intervention since resident no longer needed the splint.</p> <p>Please see exhibit C.</p> <p>Resident #3's care plan was reviewed and updated on September 26, 2013 by taking off the soft boot as intervention since resident no longer needed the boot.</p> <p>Please see exhibit C.</p> <p>Resident #6's care plan was reviewed and revised on September 27, 2013 to include intervention to address her increased dementia and also to include a care plan for pain.</p> <p>Please see exhibit C.</p>	
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F 280	<p>Continued From page 5 carrot (cone shaped device for finger positioning) and/or rolled wash cloth.</p> <p>Resident #1's Active Orders (recapitulation physician orders) for September 2013, documented an order to apply hand carrot to right hand for 8 hours per day with a start date of 6/20/13.</p> <p>On 9/26/13 at 11:05 AM, the DON stated the resident did not have a brace and the care plan needed to be revised.</p> <p>2. Resident #3 was admitted to the facility on 9/27/11 with diagnoses of dementia with behaviors, chronic pain, hypothyroidism, and Alzheimers disease.</p> <p>Resident #3's care plan for pressure ulcers, dated 2/26/13, included in the intervention section to protect the left foot and ankle with a soft boot. The resident was observed without a left boot on: 9/23/13 at 2:10 PM, and on 9/24/13 at 8:15 AM, 10:25 AM and 9/26/13 at 10:30 AM.</p> <p>On 9/26/13 at 11:45 AM, the DON was asked about the boot to protect Resident #3's left ankle. The DON stated the care plan should have been revised as the resident no longer needed the boot.</p> <p>3. Resident #6 was admitted to the facility on 9/4/13 with diagnoses of chronic airway obstruction, atrial fibrillation, rheumatoid arthritis, hypertension, anemia, senile dementia, and above the knee bilateral amputation.</p> <p>Resident #6's Admission MDS assessment, dated 9/16/13, documented the resident had moderately</p>	F 280	<p>Resident #8's care plan was reviewed and revised on September 30, 2013 to address behaviors of pinching, wandering, grabbing others and spitting on the floor.</p> <p>Please see exhibit C.</p> <p>Resident # 2's care plan was reviewed and updated on September 26, 2013 and again on October 2, 2013 to take out the preference of sitting in a recliner in the front lobby.</p> <p>Resident # 2's behavioral care plan was reviewed and revised on September 26, 2013 to list each behavior and its individual intervention.</p> <p>Please see exhibit C.</p> <p>Resident #5's care plan was reviewed and updated on September 30, 2013 to ensure that food preferences are listed and the preference of shower over bathing is addressed and clearly stated.</p> <p>Please see exhibit C.</p>	

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F 280	<p>Continued From page 6</p> <p>impaired cognition. Resident #6's medical record documented at the previous facility she rolled out of bed when she forgot she didn't have legs. During the initial tour on 9/23/13 at 12:15 PM, the surveyor was informed by the RSD the resident was interviewable in the mornings only as "her dementia gets worse in the afternoon."</p> <p>Resident #6's care plan for fall interventions, dated 9/19/13, documented to "remind the resident not to lean too far forward." The care plan did not include interventions to address her increased dementia, such as increased supervision, etc.</p> <p>Additionally, Resident #6's MAR for September 2013, included an order for Tylenol with Codeine 300/30mg (milligrams) every 4 hours PRN (as needed) for pain. The MAR for September 2013, documented the resident received medication on 9/19/13, 9/23/13, 9/24/13, and 9/25/13. However, the resident's medical record did not include a care plan for pain.</p> <p>On 9/26/13 at 3:05 PM, LN #3 was informed Resident #6's care plan for fall interventions, dated 9/19/13, did not include interventions other than reminding the resident who had senile dementia to not lean forward. LN#3 stated the care plan should be revised.</p> <p>4. Resident #8 was admitted to the facility on 7/27/10 with diagnoses of undersocialized conduct disorder aggressive type, abnormality of gait, UTI, dementia, calculus of kidney, and Alzheimer's disease.</p> <p>Resident #8's Annual MDS assessment, dated 6/25/13, documented in part:</p>	F 280	<p>Resident #7's care plan was reviewed and revised on September 30, 2013 to remove the intervention of sitting in common area for monitoring. Resident #7 has being moved to a room close to the nurse's station and prefer to stay in the recliner in his room.</p> <p>Please see exhibit C.</p> <p>All residents have the potential to be affected by this practice.</p> <p>Care plans for every residents with recent change of status were reviewed and revised to reflect resident's current status and needs.</p>	
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F 280	<p>Continued From page 7</p> <ul style="list-style-type: none"> *Hallucinations and delusions. *Physical behaviors toward others occurred 4-6 days per week. *Rejection of Care occurred 1-3 days per week. *Wandering occurred daily. <p>Resident #8's Quarterly MDS assessment, dated 9/25/13, documented in part:</p> <ul style="list-style-type: none"> *Hallucinations and delusions. *Behaviors not directed toward others occurred 1-3 days per week. *Rejection of cares occurred daily. *Wandering occurred daily. <p>Resident #8's medical record included a care plan for ADL self care performance, dated 11/14/10, which included aggressive behaviors related to dementia. The intervention section documented the resident was resistive to care and "she requires 2 staff assist with some ADL's, follow behavior monitoring care plan when this occurs."</p> <p>On 9/26/13 at 11:58 AM, the DON was asked what behaviors Resident #8 exhibited. The DON stated the resident was resistive to cares, swats people on the bottom, hits at staff during cares but was mainly resistive to cares. The surveyor asked if the facility was tracking behaviors and if they had a care plan for behaviors. The DON stated she would check for a behavior care plan.</p> <p>On 9/26/13 at 1:52 PM, the RSD provided Behavior Tracking Sheets for the month of June 2013 which tracked behaviors of:</p> <ul style="list-style-type: none"> *Wandering - interventions to redirect, encourage activities & offer food and toileting. *Grabbing others - interventions to offer activity, 	F 280	<p>MDS nurse will review and revise care plans for every resident with change of status and ensure that care plan will reflect resident's current status and needs.</p> <p>IDT will audit and review resident with recent change of condition and per MDS schedule to ensure care plan will reflect resident's current status and needs. Audits and monitoring will be weekly X 4, then every 2 weeks X 4, then monthly X 3.</p> <p>All audits will be reviewed at monthly CQI meeting.</p> <p>Audits will start on October 16, 2013.</p>	

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

PRINTED: 10/04/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135056	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/27/2013
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F 280	<p>Continued From page 8</p> <p>positive reassurance, offer to get RSD or LPN, redirect, and reproach.</p> <p>*Spitting on the floor - interventions to offer towel or Kleenex, positive reassurance, offer to get RSD or LPN, redirect and offer to go for walk or outside activity.</p> <p>Resident #8's medical record did not include a behavior care plan which addressed behaviors of pinching, wandering, grabbing others or spitting on the floor.</p> <p>On 9/26/13 at 3:52 PM, the Administrator and the DON was made aware of the above care plan issues, however, no further information was provided.</p> <p>5. Resident #2 was admitted to the facility 1/29/13 and readmitted on 3/29/13 with diagnoses of dementia with lewy bodies, unspecified psychosis, undersocialized conduct disorder, depressive disorder and paralysis agitans.</p> <p>The significant change MDS assessment, dated 4/5/13, documented the resident: * was severely cognitively impaired with a BIMS of 0, * required extensive assistance for transfers, dressing, eating, toilet use, personal hygiene and bathing.</p> <p>The resident's care plan, dated 7/10/13, documented interventions for the focus area of physical functioning of: "I require extensive assist of staff for transfers. I ambulate as outlined in RNA program with FWW [front wheel walker] with extensive assistance." and, "I set in a recliner chair in the front lobby</p>	F 280		

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F 280	<p>Continued From page 9</p> <p>throughout the day and night because that is what is most comfortable for me because my neck falls forward [due to] my Parkinson's. I rarely use my room. I like to have television on that is in front of my recliner."</p> <p>The resident's care plan, dated 4/13/13, documented interventions for behavior problems of: *Minimize potential for my disruptive behaviors (Specify) by offering tasks which divert attention such as (Specify).</p> <p>The DON was interviewed on 9/26/13 at 9:15 a.m. about the care plan. She stated the resident; * no longer participates in the RNA ambulation program, * the resident no longer sits in the lobby but has a recliner in his room where he spends all of his time, and * the resident's behaviors were not listed in the care plan, nor were the interventions. She indicated in the interview the care plan should have been updated and revised with the changes.</p> <p>6. Resident #5 was admitted to the facility 10/26/12 with diagnoses of diabetes without complications type II, major depressive disorder, hallucinations and unspecified paranoid state.</p> <p>The most recent quarterly MDS assessment, dated 6/11/13, documented the resident was cognitively intact with a BIMS of 14 and independent for ADLs of bed mobility, transfers, dressing, eating, and personal hygiene.</p> <p>The residents care plan, dated 10/26/12, documented for physical functioning:</p>	F 280			

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F 280	<p>Continued From page 10</p> <p>"*Apply preferred lotion (specify) after bathing. *I prefer the following foods. [Note: there was no listing of any foods.] *Prefers bath. *Prefers shower."</p> <p>The resident's care plan was not clear whether she preferred a bath or a shower.</p> <p>The DON was interviewed on 9/26/13 at 9:05 a.m. about the inconsistencies in the resident care plan. She indicated the care plan should have been updated with accurate information.</p> <p>7. Resident #7 was admitted to the facility on 7/15/13 with diagnoses of dementia unspecified with behavior disturbances, unspecified psychosis, blindness both eyes, late effect cerebrovascular disease and diabetes mellitus.</p> <p>The admission MDS assessment, dated 7/22/13, documented the resident was severely cognitively impaired with a BIMS of 7, needed limited assistance with ADLs.</p> <p>The resident's care plan, dated 7/29/13 documented at risk for falls the resident was to "Set in common area, for monitoring."</p> <p>The resident was observed in his room in a recliner during the survey and not in the common area.</p> <p>The DON was interviewed on 9/26/13 at 9:20 a.m. and stated the resident was moved to a room closer to the nurses station after the last fall. The resident no longer was to sit in the common area and preferred to sit in the recliner in his room. The care plan should have been</p>	F 280		
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F 280	Continued From page 11 revised.	F 280		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility had failed to reassess a resident that was incontinent to determine if toilet training would benefit him. This was true for 1 of 9 (# 2) sampled residents. There was a potential for harm to the resident due to a loss of bladder function and the secondary effects of incontinence. Findings include: Resident #2 was admitted to the facility 1/29/13 and readmitted on 3/29/13 with diagnoses of dementia with lewy bodies, unspecified psychosis, undersocialized conduct disorder aggressive, depressive disorder and paralysis agitans. The significant change MDS assessment, dated 4/5/13, documented the resident: * was severely cognitively impaired with a BIMS of 0,	F 315	F 315 NO CATHETER, PREVENT UTI, RESTORE BLADDER The facility will ensure to reassess a resident that was incontinent to determine if toilet training would benefit a resident. All residents have the potential to be affected by this practice. A baseline voiding assessment for resident # 2 was completed and Toileting or Bowel and Bladder program was implemented on September 30, 2013. A 3 day Toileting monitor was implemented by MDS Nurse on September 30, 2013 for Resident #2 and every resident per MDS schedule. MDS Nurse will assess and review and implement a 3 day toileting monitor to every resident per MDS schedule to determine if toileting would benefit the resident.	10/18/13

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F 315	<p>Continued From page 12</p> <ul style="list-style-type: none"> * required extensive assistance for transfers, dressing, eating, toilet use, personal hygiene and bathing, * was always incontinent of bladder and frequently incontinent of bowel. <p>The quarterly MDS assessment, dated 7/2/13, documented the resident:</p> <ul style="list-style-type: none"> * was moderately cognitively impaired with a BIMS of 9, * required extensive assistance for transfers, dressing, eating, toilet use, personal hygiene and bathing, * was frequently incontinent of urine and continent of bowel. <p>[Note: The resident had improved from severe to moderate cognitive impairment]</p> <p>The facility completed an admission bladder incontinence evaluation form on 3/29/13. There was lacking documentation the facility evaluated the resident's voiding pattern for the assessment. The conclusion of the assessment was "Unable to participate in program." The reason was: "Dementia, urinary frequency and BPH. [benign prostate hypertrophy]</p> <p>The resident was reevaluated on 7/10/13 and the assessment documented, "There has been no [change] in incontinent status." The facility failed to address the resident's dementia had improved and in addition the frequency of incontinence of urine had declined. There was no documentation to show the facility attempted to identify when the resident was incontinent.</p> <p>The resident's care plan, revised 7/10/13, documented, "I have physical functioning impairment [due/to] my diagnosis of Parkinson</p>	F 315	<p>IDT will audit and review residents per MDS schedule in the weekly meeting to ensure and determine if toileting would benefit the resident. Audits and monitoring will be weekly X 4, then every 2 weeks X 4, then monthly X 3.</p> <p>Please see exhibit D .</p> <p>All audits will be reviewed at monthly CQI meeting.</p> <p>Audit will start October 16, 2013.</p>		

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F 315	Continued From page 13 with chronic pain. I require extensive assist of 1 - 2 staff for ADLs, care and mobility." The intervention for toileting documented, " I require extensive of staff for toileting needs. I am sometimes incontinent of bowel and bladder. Most of the time I am able to make my bowel and bladder needs known through verbal communication or let you know that I have been incontinent. I wear incontinent briefs in order to promote skin integrity and to maintain dignity. Take me to the toilet when I ask. Check and change me [every] 2 hours and [as needed]...." [Note: Most of the the time the resident could communicate incontinence.] The MDS Coordinator was interviewed on 9/26/13 at 11:20 a.m. and asked why there was no baseline voiding assessment completed for the resident. She stated with the resident's improvement in cognition the resident should have had a three day voiding completed as there was a potential for the resident to have a restorative program for bladder retraining. The Administrator and DON were informed 9/26/13 at 4:00 p.m. No further information was provided.	F 315			
F 329 SS=E	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	F 329	F 329 DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS The facility will ensure to consistently monitor and consider risk identified in the black box warning and ensure to prevent duplicate therapy.	10/18/13	

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F 329	<p>Continued From page 14 combinations of the reasons above.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to consider the risk identified in the black box warning and to prevent duplicate therapy. Additionally, the facility failed to implement non-pharmacological interventions prior to administering unnecessary drugs. This was true for 4 of 10 sampled residents (#s 1,2,6 & 9). This created the potential for harm to residents as unnecessary drugs can lead to adverse reactions and health decline. Findings included:</p> <p>1. Resident #1 was admitted to the facility on 9/20/12 with diagnoses of bronchitis, prolonged depression, weight loss, CVA (cerebrovascular accident), chronic pain, delay in development and dementia with behaviors.</p> <p>Resident #1's Active Orders for September 2013,</p>	F 329	<p>The facility will also ensure to implement a non- pharmacological intervention prior to administering unnecessary drugs.</p> <p>All residents have the potential to be affected by this practice.</p> <p>Resident #1 and Resident #6's POA was contacted by phone on September 27, 2013 and was verbally informed of the Black Box Warning. And a new form outlining the risk was mailed to POA on September 30, 2013 to them to sign.</p> <p>RSD and Medical record Nurse reviewed all residents with diagnosis of dementia and are having antipsychotics medication to ensure that resident/family/POA are informed of the black box warning.</p>	
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F 329	<p>Continued From page 15 (physician recapitulation orders) included an order for Fluphenazine HCl 2.5 mg (milligram) two times a day, everyday with a start date of 8/16/13, for unspecified psychosis manifested by disruptive loud vocals and psychotic agitation with psychosis. The MAR documented the resident received the Fluphenazine as ordered.</p> <p>According to Wolters Kluwer/Lippincott Williams & Wilkins Nursing 2013 Drug Handbook, 33rd Edition, page 612, under Nursing Considerations for Fluphenazine, the Black Box Warning states, "Elderly patients with dementia-related psychosis treated with atypical or conventional antipsychotics are at increased risk for death."</p> <p>Resident #1's medical record did not document the facility had considered or informed the resident/family of the Black Box Warning.</p> <p>2. Resident #6 was admitted to the facility on 9/4/13 with diagnoses of chronic airway obstruction, atrial fibrillation, rheumatoid arthritis, hypertension, anemia, senile dementia, and above the knee bilateral amputation.</p> <p>Resident #6's Admission MDS assessment, dated 9/16/13, documented the resident had hallucinations with verbal behavioral symptoms directed toward others which occurred 4-6 days per week.</p> <p>Resident #6's admission orders included an order for Seroquel 12.5 mg daily for the diagnosis of dementia with manifestation of anxiety evidenced by loud vocals.</p> <p>According to Wolters Kluwer/ Lippincott Williams</p>	F 329	<p>Medical record and RSD will ensure that any new orders for antipsychotics medication for resident with diagnosis of dementia, that the resident or family or POA will be notified or informed of the black box warning prior to medication being started.</p> <p>IDT will review and audit resident per MDS schedule for black box warning notification weekly. Audits and monitoring will be weekly X 4, then every 2 weeks X 4, then monthly X 3.</p> <p>Please see exhibit E.</p> <p>All audits will be reviewed at monthly CQI meeting.</p>	
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F 329	<p>Continued From page 16</p> <p>& Wilkins Nursing 2013 Drug Handbook, 33rd Edition, page 1153, under Nursing Considerations for Seroquel, the Black Box Warning states, "Drug isn't indicated for use in elderly patients with dementia-related psychosis because of increased risk of death from CV (cardiovascular) disease or infection."</p> <p>On 9/26/13 at 12:05 PM, the DON was asked for documentation of the Black Box Warning. No further documentation was provided.</p> <p>On 9/26/13 at 1:50 PM, the RSD stated they do not have Black Box Warnings for their residents.</p> <p>Resident #6's medical record did not document the facility had considered or informed the resident/family of the Black Box Warning.</p> <p>3. Resident #9 was originally admitted to the facility on 6/22/12 with readmission dates of 4/28/13 and 5/21/13 with diagnoses of rehab, dysphagia, gastritis and polyneuropathy.</p> <p>Resident #9's MAR for September 2013, documented an order, with a start date of 5/22/13, for Trazodone 50 mg at HS (bedtime) daily for depression and insomnia.</p> <p>Resident #9's medical record did not include a care plan for sleep. However, his care plan for pain, with a start date of 6/10/13, documented in the intervention section, to observe and report changes in usual routine and sleep patterns.</p> <p>The facility provided a TAR, with a start date of 5/22/13, which documented hours of sleep every shift daily, but a care plan for sleep was not provided.</p>	F 329	<p>Resident #9's care plan was reviewed and revised on September 27, 2013 to include a care plan for sleep and non-pharmacological interventions prior to the use of antidepressant for sleep.</p> <p>RSD and MDS nurse reviewed every resident with sleeping problem that have an order of antidepressants to ensure that a care plan for sleep is in place a non-pharmacological interventions are implemented prior to the use of antidepressant when resident is having problem sleeping.</p> <p>IDT will review every resident with sleeping problem that have a new order for antidepressant in the weekly IDT meeting to ensure that care plan for sleep is in place and a non-pharmacological intervention is implemented prior to the use of antidepressant when having problem sleeping.</p>	
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F 329	<p>Continued From page 17</p> <p>On 9/27/13 at 10:15 AM, the RSD was asked for documentation of non-pharmalogical interventions for sleep for Resident #9. She stated a care plan should have been developed which included interventions of soft lights and to call his daughter when he could not sleep.</p> <p>The facility failed to develop a care plan or implement non-pharmalogical interventions prior to the use of an antidepressant for sleep.</p> <p>4. Resident #2 was admitted to the facility 1/29/13 and readmitted on 3/29/13 with diagnoses of dementia with lewy bodies, unspecified psychosis, undersocialized conduct disorder, depressive disorder and paralysis agitans.</p> <p>The significant change MDS assessment, dated 4/5/13, documented the resident: * was severely cognitively impaired with a BIMS of 0, * required extensive assistance for transfers, dressing, eating, toilet use, personal hygiene and bathing, * was always incontinent of bladder and frequently incontinent of bowel.</p> <p>Review of the physician recapitulation for August 2013 documented the resident received, "Docusate Sodium 100 mg two capsules orally two times a day, every day and Senokot S (Sennosides - Docusate sodium) 8.6 - 50 mg tablet orally twice a day.</p> <p>The pharmacist identified the two medications as being the same and on 9/4/13 requested the physician to write a rationale for using duplicate</p>	F 329	<p>IDT will review per MDS schedule current resident with sleeping problem that have an order for antidepressant to ensure that care plan for sleep is in place and a non-pharmacological intervention is implemented prior to the use of antidepressant when having problem sleeping. Audits and monitoring will be weekly X 4, then every 2 weeks X 4, then monthly X 3.</p> <p>Please see exhibit E.</p> <p>All audits will be reviewed at monthly CQI meeting.</p> <p>Resident # 2's medication Docusate sodium 100 mg two capsules orally two time a day, everyday was discontinued by the physician on September 26, 2013 to avoid duplicate therapy.</p> <p>DNS and Medical Records Nurse reviewed the latest Pharmacy consult to ensure that a physician's rationale is documented for every resident with duplicate therapy.</p>		

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F 329 Continued From page 18 medications. A physician assistant responded and declined the recommendation. The medical record failed to document the reason for duplicate therapy.

The DON was interviewed on 9/26/13 at 9:15 p.m. and indicated that she would discuss the problem with the physician.

The physician was contacted during the survey and the Docusate Sodium 100 mg two capsules orally two times a day, every day was discontinued on 9/26/13 at 2:00 p.m.

F 431 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS
SS=E

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.

F 329 DNS will review the pharmacy consult after every monthly medication review to ensure that concerns from the pharmacist in regards to a rationale for using duplicate medications are addressed timely.

Medical records nurse will review any new order to assure that when medication is duplicate therapy that physician rationale is documented.

F 431 IDT will review resident's medication list per MDS schedule in the weekly IDT meeting. Audits and monitoring will be weekly X 4, then every 2 weeks X 4, then monthly X 3.

Please see exhibit E.

All audits will be reviewed at monthly CQI meeting.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135056	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/27/2013
NAME OF PROVIDER OR SUPPLIER LINCOLN COUNTY CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 511 EAST FOURTH STREET SHOSHONE, ID 83352		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 431	<p>Continued From page 19</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure medications were stored in locked areas and not accessible to residents. This was true for 1 of 2 medication carts which were left unlocked and unattended in a hallway. This created the potential for more than minimal harm for any cognitively impaired and independently mobile residents, if they ingested the accessible medications. Findings included:</p> <p>On 9/24/13 at 12:45 PM, 3 surveyors observed the medication cart for the West Hall was unlocked and unattended while it was parked in the hallway. One surveyor opened one drawer on the left side and notified the Administrator. Hundreds of prescription and over-the-counter medications were in the drawers.</p> <p>On 9/24/13 at 12:50 PM, the Administrator was made aware the medication cart was unlocked and pushed in the lock.</p> <p>On 9/25/13 at 12:05 PM, LN #4 stated she was the nurse who left the medication cart unlocked.</p>	F 431	<p>F 431</p> <p>DRUG RECORDS, LABEL/STORE DRUGS AND BIOLOGICALS</p> <p>The facility will ensure that medications were stored in locked areas and not accessible to residents.</p> <p>All residents have the potential to be affected by this practice.</p> <p>LN # 4 was counseled on the potential risk for leaving the medication cart unlocked on September 25, 2013.</p> <p>Licensed Nurses were in serviced with this Federal Tag F431 and the potential risk of leaving the medication cart unlocked when unattended.</p> <p>D.N.S. or Department head licensed staff will do a medication and treatment cart check to assure that the cart are locked when unattended. Checks will be weekly X 4 and then every 2 weeks X 4 and then monthly X 3.</p> <p>Audits will start on October 15, 2013.</p> <p>Please see exhibit <u>FF</u></p>	10/18/13	

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F 431	Continued From page 20 She reported she is usually obsessive about locking the cart but admitted she left the medication cart unlocked. On 9/26/13 at 3:52 PM, the facility was informed of the unlocked and unattended medication cart. No other information was received from the facility regarding the issue.	F 431		
F 514 SS=B	483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to accurately document and maintain clinical records. This was true for 3 of 11 sampled residents, (#s 1, 6, & 11). Findings included: 1. Resident #1 was admitted to the facility on 9/20/12 with diagnoses of bronchitis, prolonged depression, weight loss, CVA (cerebrovascular accident), chronic pain, delay in development and	F 514	F 514 RECORDS-COMplete/ACCURATE/ACCESSIBLE The facility will ensure resident's clinical records were complete and accurate. All residents have the potential to be affected by this practice. Licensed Nurses and Medical Records Nurse were in serviced on this Federal Tag F514.	10/18/13

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135056	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/27/2013
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F 514	<p>Continued From page 21 dementia with behaviors.</p> <p>Medical record review of Resident #1's POST (Physician Orders For Scope of Treatment) did not include the resident's date of birth, the basis for the POST order or the date Resident #1's brother signed the POST.</p> <p>Additionally, Resident #1's medical record included an order, dated 8/7/13, from the RD to discontinue CIB (Carnation Instant Breakfast) with coffee and half & half. The order remained on the Active Orders (physician recapitulation orders) for September 2013.</p> <p>Resident's #1's medical record included a progress note, dated 8/22/13 at 14:21 (2:21 PM), which documented, "No adverse effects noted related to fall. No c/o [complaint of] pain. Laceration to head dry, no s/d [signs/sic] infection. Legs elevated as resident would allow."</p> <p>On 9/26/13 at 11:05 AM, the DON was asked for an Incident Report related to the fall documented on Resident #1's progress note, dated 8/21/13 at 16:42 (4:42 PM). The DON stated she wasn't aware of a fall and thought it was charted on the wrong chart. The DON stated Resident #11 had a fall on 8/19/13. The DON provided a copy of the Accident/Incident Tracking Log for the month of August 2013, along with a copy of the Incident/Accident IDT (Interdisciplinary Team) Review with the date of occurrence listed as 8/19/13 at 2:45 AM.</p> <p>On 9/26/13 at 11:05 AM, the DON was informed Resident #1's POST did not include the resident's date of birth, the basis for the order which was signed by the resident's brother, or the date the</p>	F 514	<p>Clinical records or charts for resident # 1, #6, #11 and of other residents was reviewed by the DNS, RSD and Medical Record to assure that a complete and accurate records are in place on each individual charts or records.</p> <p>Resident # 1's POST was updated to include the resident's date of birth, the basis for POST order or the date Resident #1's brother signed the POST</p> <p>Resident # 1's recapitulation was updated on September 26,2013 to remove CIB (carnation Instant Breakfast) with coffee and half and half.</p> <p>Resident # 1 and #11's clinical records was reviewed and the wrong documentation regarding the fall was noted as charting error on Resident # 1's clinical record.</p>	

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F 514	<p>Continued From page 22</p> <p>brother signed the POST. The DON observed a copy of the POST which was in the chart and agreed with the findings. The DON was also informed the CIB order was still on the physician recapitulation orders for September 2013.</p> <p>On 9/26/13 at 2:00 PM, the RSD stated she called Resident #1's brother and, with his permission, had revised the POST to include the date of birth and checked the basis for the POST order as "Patient's known preference."</p> <p>On 9/26/13 at 2:30 PM, LN #1 reported she missed discontinuing the CIB under diet in the physician recapitulation orders for September 2013.</p> <p>2. Resident #6 was admitted to the facility on 9/4/13 with diagnoses of chronic airway obstruction, atrial fibrillation, rheumatoid arthritis, hypertension, anemia, senile dementia, and above the knee bilateral amputation.</p> <p>Record review of Resident #6's POST (Physician Orders For Scope of Treatment) did not include the resident's date of birth or the basis for the POST order which was signed by the resident's POA (Power of Attorney). In addition, the POST did not include the date the POST was signed by the resident's POA.</p> <p>On 9/26/13 at 12:05 PM, the DON was informed Resident #6's POST did not include the resident's date of birth, the basis for the order which was signed by the resident's POA or the date the POA signed the POST. The DON observed a copy of the POST which was in the chart and agreed with the findings.</p>	F 514	<p>Resident # 6's POST was updated to include the resident's date of birth, the basis for POST order or the date Resident #6's POA signed the POST.</p> <p>Business Office Manager will audit POST for accuracy on every new admission or revision.</p> <p>Licensed staff charting will be reviewed and read every Monday - Friday in the department head meeting to assure charting accuracy.</p> <p>IDT team will audit POST and recapitulation per MDS schedule weekly X 4 and then every two weeks X 4 and then monthly X 3 at weekly IDT meeting.</p> <p>Please see exhibit F.</p> <p>All audits will be reviewed at monthly CQI meeting.</p> <p>Audits will start on October 16,2013.</p>	
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F 514	Continued From page 23 On 9/26/13 at 3:10 PM, LN #2 handed the surveyor of copy of Resident #6's revised POST which included the resident's date of birth and the basis for the POST order as "Patient's known preference."	F 514			

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001860	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/27/2013
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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 annual licensure survey of your facility.</p> <p>The surveyors conducting the survey were: Arnold Rosling, RN, BSN, QMRP Sherri Case, LSW Becky Thomas, RN</p>	C 000		
C 125	<p>02.100,03,c,ix Treated with Respect/Dignity</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; This Rule is not met as evidenced by: Please refer to F-241 as it relates to dignity.</p>	C 125	<p>Please refer to Tag F 241</p> <p style="text-align: center;">RECEIVED OCT 21 2013 FACILITY STANDARDS</p>	10/18/13
C 147	<p>02.100,05,g Prohibited Uses of Chemical Restraints</p> <p>g. Chemical restraints shall not be used as punishment, for convenience of the staff, or in quantities that interfere with the ongoing normal functions of the patient/resident. They shall be used only to the extent necessary for professionally accepted patient care management and must be ordered in writing by the attending physician. This Rule is not met as evidenced by: Please refer to F-329 as it refers to unnecessary</p>	C 147	<p>Please refer to Tag F 329.</p>	10/18/13

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

Dawin Royce

TITLE

Administrator

(X6) DATE

10/18/13

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001860	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/27/2013
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C 147	Continued From page 1 drugs	C 147		
C 782	02.200,03,a,iv Reviewed and Revised iv. Reviewed and revised as needed to reflect the current needs of patients/residents and current goals to be accomplished; This Rule is not met as evidenced by: Please refer to F-280 as it refers to plan of care review and revision.	C 782	Please refer to Tag F 280.	10/18/13
C 795	02.200,03,b,xi Bowel/Bladder Evacuation/Retraining xi. Bowel and bladder evacuation and bowel and bladder retraining programs as indicated; This Rule is not met as evidenced by: Please refer to F-315 as it relates to bladder training.	C 795	Please refer to Tag F 315.	10/18/13
C 838	02.201,02,I Secure Storage of Medications I. All medications in the facility shall be maintained in a locked cabinet located at, or convenient to, the nurses' station. Such cabinet shall be of adequate size, and locked when not in use. The key for the lock of this cabinet shall be carried only by licensed nursing personnel and/or the pharmacist. This Rule is not met as evidenced by: Please refer to F-431 as it relates to locked storage of medications.	C 838	Please refer to Tag F 431.	10/18/13

Bureau of Facility Standards

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C 881	Continued From page 2	C 881		
C 881	02.203,02 INDIVIDUAL MEDICAL RECORD 02. Individual Medical Record. An individual medical record shall be maintained for each admission with all entries kept current, dated and signed. All records shall be either typewritten or recorded legibly in ink, and shall contain the following: This Rule is not met as evidenced by: Please refer to F-514 as it relates to Accuracy of Records.	C 881	Please refer to Tag F 514	10/10/13