



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

December 2, 2014

Rod Jacobson, Administrator
Bear Lake Memorial Skilled Nursing Facility
164 South Fifth Street
Montpelier, ID 83254-1557

FILE COPY

Provider #: 135070

RE: Corrected Copy of the October 24, 2014, Recertification and State Licensure Survey Cover Letter dated November 5, 2014

Dear Mr. Jacobson:

On **November 5, 2014**, your facility was sent a certified letter (7007 3020 0001 4038 9673) from our office notifying you of the results of the October 24, 2014, Recertification and State Licensure survey. It was discovered that this certified letter contained wrong dates on pages 2 and 3. Please replace the previously sent letter of November 5, 2014, with this corrected copy.

On **October 24, 2014**, a Recertification and State Licensure survey was conducted at Bear Lake Memorial Skilled Nursing Facility 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 a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies and a similar State Form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be

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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 **November 18, 2014**. Failure to submit an acceptable PoC by **November 18, 2014**, may result in the imposition of civil monetary penalties by **December 8, 2014**.

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

- Address what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- Address how you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- Address what measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;
- Indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained.
- Include dates when corrective action will be completed in column (X5).

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

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

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

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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 28, 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 **November 28, 2014**. A change in the seriousness of the deficiencies on **November 28, 2014**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **November 28, 2014**, includes the following:

Denial of payment for new admissions effective **January 24, 2015**. [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 **April 24, 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.I.D.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 **October 23, 2014** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the noncompliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through

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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 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 **November 18, 2014**. If your request for informal dispute resolution is received after **November 18, 2014**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

We apologize for any inconvenience this may have caused. Should you have any questions, comments or concerns, please contact Lorene Kayser, L.S.W., Q.I.D.P. or David Scott, R.N., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, (208) 334-6626, fax (208) 364-1888.

Sincerely,



LORENE KAYSER, L.S.W., Q.I.D.P., Supervisor
Long Term Care

LKK/dmj
Enclosures

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

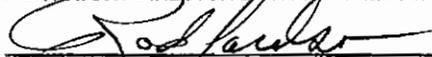
PRINTED: 11/03/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135070	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/24/2014
NAME OF PROVIDER OR SUPPLIER BEAR LAKE MEMORIAL SKILLED NURSING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 164 SOUTH FIFTH STREET MONTPELIER, ID 83254	
(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 and state licensure survey of your facility conducted October 20, 2014 through October 24, 2014. The surveyors who conducted the survey were: Linda Kelly, RN, Team Coordinator, and Linda Hukill-Neil, RN. Survey Definitions: ADL = Activities of Daily Living AIT = Administrator in Training CAA = Care Area Assessment CNA = Certified Nurse Aide DNS = Director of Nursing Services LN = Licensed Nurse MAR = Medication Administration Record MDS = Minimum Data Set assessment	F 000		
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 resident and staff interview, it was determined the facility failed to ensure a meal tray was set-up for 1 of 6 sample residents (#6) during dining observations. The failure created the potential for inadequate	F 246	RECEIVED NOV 13 2014 FACILITY COMPLAINTS F-246: Corrective actions for those affected by the practice include: Staff members were re-educated in proper positioning for resident #6 immediately and will be further educated on proper positioning of all residents who eat in bed at an inservice on 11-13-14. All residents who eat their meals in bed have the potential for inadequate nutrition if they are unable to access their meal. Residents will be positioned properly to enable them to access their meal. Measures that will be put into place to ensure the practice does not recur include: Random monitoring will be	

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

TITLE

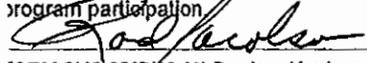
(X6) DATE



Admin

11-14-14

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 246	<p>Continued From page 1</p> <p>nutrition when the resident's meal tray was not at an appropriate level, her milk carton was not opened, and the milk and a glass were not within her reach. Findings included:</p> <p>On 10/22/14 at 6:35 p.m., Resident #6 was observed on her back in bed with the head of the bed elevated to 45 degrees. The resident's meal tray was on the slide out portion of her over bed table which was chin level to the resident. The over bed table was over 2 right side bedrails both of which were in the raised position. The resident's unopened carton of 2% reduced fat milk and an upside down red glass were at the back edge of the top portion of the bedside table. When asked if the meal tray was too high, the resident shrugged her shoulders and stated, "There's nothing I can do about it." When asked if she could reach the milk, the resident said "No." When asked if she would drink the milk if she could reach it. the resident said "Yes."</p> <p>On 10/22/14 at 6:45 p.m., Cook #1, who was in the hallway at the time, accompanied the surveyor into the resident's room. When asked about the resident's meal tray, the Cook said it was "too high" and, "That would be [Kitchen Helper #2's name]. She set-up the trays." The Cook was asked about the unopened milk carton and glass at the back edge on the top portion of the over bed table. The Cook acknowledged that the milk and glass were too far away for the resident to reach them. The Cook asked the resident if she would like her to open the milk. The resident responded, "Not now. I'm full."</p> <p>On 10/22/14 at 7:15 p.m., the AIT and DNS were informed of the issue. The facility did not provide any other information regarding the issue.</p>	F 246	<p>(continued from page 1)</p> <p>performed during meal times to assure proper positioning of residents who request to eat their meals in bed.</p> <p>The DNS, Social Worker, or Licensed Nurse will perform audits at meal times daily x 2 weeks, then weekly x 1 month, then monthly thereafter.</p>	11-13-14

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F 280 SS=E	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>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.</p> <p>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, 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 record review and staff interview, it was determined the facility failed to ensure care plans were periodically reviewed and revised/updated to reflect residents' current status and that identified problems and care planned interventions were dated for 7 of 9 sample residents (#s 1-7). The failures created the potential for harm if staff did not provide the appropriate care due to outdated and/or conflicting directions in the care plans for Resident #2's indwelling urinary catheter change and the amount of feeding assistance she needed, Resident #1's dressing changes, and/or</p>	F 280	<p>F-280: Corrective actions for those affected by the practice include: The care plan for resident #2 was updated to reflect the correct frequency of catheter changes and the amount of feeding assistance required. The care plan for resident #1 was updated to reflect the current status of pressure ulcers (healed.) The care plans for residents #1,2,3,4,5,6, and 7 were updated with dates of problems, goals, and interventions.</p> <p>All residents are at risk of harm if care plans are not updated to reflect the resident's current status to direct staff in providing appropriate care.</p> <p>Care plans will be updated quarterly and whenever a change in status occurs.</p> <p>Measures that will be implemented to ensure the practice does not recur include: The current care plan format has been revised to include dates of problems, goals, and intervention. Care plans will be reviewed by nursing staff weekly to ensure their accuracy.</p> <p>Audits will be performed by the DNS or other Licensed Nurse weekly x 3 months then monthly thereafter.</p>	11-13-14	

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F 280	<p>Continued From page 3</p> <p>the inability to determine when problems were identified and interventions were started for Residents #1-7. Findings included:</p> <p>1. Resident #2 was admitted to the facility in 2010 with multiple diagnoses which included neurogenic bladder and Parkinson's disease.</p> <p>The resident's current physician's orders for October, 2014 included mechanical soft diet and Foley catheter change 2 times per month.</p> <p>The resident's undated self care deficit care plan included the undated intervention, "...able to feed herself with cueing and oversight from staff. She requires extra time for eating. Allow her the time she needs to finish meals." However, her undated alteration in nutrition care plan included the undated intervention, "Needs one person assistance for eating..."</p> <p>The resident's care plan also documented, "Risk for infections r/t [related to] an indwelling Foley catheter..." There was no date for this problem or for any of the interventions for the problem which included, "Change monthly and PRN [as needed]..."</p> <p>On 10/21/14 at 8:30 a.m. and 12:20 p.m. and 10/22/14 at 6:15 p.m., the resident was observed independently eating a mechanical soft meal with oversight by staff and occasional cueing.</p> <p>The resident was observed with a Foley catheter in place at 5:05 p.m. on 10/20/14; five times between at 8:30 a.m. and 3:15 p.m. on 10/21/14; and, three times on 10/22/14.</p> <p>On 10/22/14 at 10:35 a.m., the DNS was asked</p>	F 280			

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F 280	<p>Continued From page 4</p> <p>about the resident's care plan. Regarding the bowel and bladder care plan, the DNS said the resident's urologist ordered two times a month catheter change on 6/26/14. She stated, "It [care plan] should have been changed after that." Regarding how much assistance versus oversight and cueing was needed, the DNS stated, "It should have been updated to oversight only." Regarding no dates for problems and interventions, the DNS said she knew dates may not be on the current care plans. The DNS said the facility's computer program did not automatically list dates for care plan problems and interventions and that dates for each problem and intervention had to be manually typed each time.</p> <p>Refer to F514 regarding missing documentation of the catheter change in October 2014.</p> <p>2. Resident #4 was admitted to the facility in 2012 with multiple diagnoses which included anxiety related to Alzheimer's dementia.</p> <p>The resident's annual MDS assessment, dated 8/26/14, coding included moderately impaired vision, severe cognitive deficit, little interest/pleasure in doing things, feeling/appearing down, depressed or hopeless, poor appetite or overeating, extensive assistance for all ADLs except eating, balance problems, bowel and bladder incontinence, scheduled and as needed pain medication and indicators of pain/possible pain for 3 to 4 of the previous 5 days, holding food in mouth/cheeks or residual food in mouth after meals and mechanically altered diet, at risk of developing pressure ulcers.</p> <p>The resident's care plan included the problem</p>	F 280		

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NAME OF PROVIDER OR SUPPLIER BEAR LAKE MEMORIAL SKILLED NURSING FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 164 SOUTH FIFTH STREET MONTPELIER, ID 83254
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F 280 Continued From page 5
areas of self care deficit, at risk for unmet needs related to severe cognitive loss, at risk for skin breakdown, impaired gas exchange, at risk for injuries from falls, at risk for weight loss, decline in activity participation related to confusion and anxiety, potential for injuries related to impaired vision, and potential for unmet needs related to pain. None of the problems included the date they were identified. In addition, for each problem area, 2 to 11 interventions were documented. However, none of the interventions included the date of implementation.

3. Resident #6 was admitted to the facility in 2012 with diagnoses that included debility and weakness, congestive heart failure, depression, and hypothyroidism.

The resident's most recent quarterly MDS assessment, dated 9/6/13, coding included , impaired vision, corrective lenses, intact cognition, extensive assistance for most ADLs except eating, frequent bladder incontinence, scheduled pain medication, no pain, one no injury fall, at risk of developing pressure ulcers, and oxygen therapy.

The resident's care plan included self care deficit, episodes of urinary and fecal incontinence, potential for unmet need related to cognitive loss, impaired gas exchange, at risk for injury from falls, at risk for weight loss, minimal activity attendance related to impaired vision, potential for side effects related to use of psychotropic medications, and at risk for skin breakdown. None of the problems included the date they were identified. In addition, for each problem area, 4 to 11 interventions were documented. However, none of the interventions included the date of

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F 280	<p>Continued From page 6 implementation.</p> <p>On 10/22/14 at 10:35 a.m., when asked about care plans with undated problem areas and interventions, the DNS said she knew that dates may not be on the current care plans. The DNS said the facility's computer program did not automatically list dates for care plan problems and interventions and that dates for each problem and intervention had to be manually typed each time. The facility did not provide any other information regarding the care plan issue.</p> <p>4. Resident #1 was admitted to the facility on 11/25/13, with multiple diagnoses including HIV, HIV encephalopathy, central tremors, and multiple pulmonary infections.</p> <p>a) The resident's current October 2014 Care Plan documented as a Long Term Care (LTC) Problem: *"...SKIN BREAKDOWN Has current stage II pressure ulcer to sacrum r/t [related to] malnutrition and decreased physical mobility secondary to disease progression." The resident's interventions for the skin breakdown were documented: *1. Change dressings per MD order. 2. Air overlay mattress to bed. Gel foam cushion to wheelchair. 3. Assist with repositioning at least hourly throughout the day..."</p> <p>Resident #1's Patient Progress Notes (Nursing Notes) documented the following: *7/17/14: "...Aide reports that he now has an open area to coccyx, non-related to fall. Ski [sic-Skin] nurses notified..." *7/19/14: "...MD in to see Resident today; new orders received...Calmoseptine applied to open</p>	F 280			

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F 280	<p>Continued From page 7 area on coccyx..."</p> <p>*8/14/14: "...Decubitus Ulcer: Diagnosed Stage II, Healing, Sacrum Right Center...Wound Care: A) Cleaned with Saf Clens, Patted Dry, Normagel applied to Wound bed only and covered with a Mepilex with Border..."</p> <p>*9/4/14: "...Skin was assessed after bath today. Stage II pressure ulcer to sacrum has healed and dressing was dc'd. Will continue with current interventions..."</p> <p>*10/22/14: "...Skin Assessment: Warm, Dry...Skin Integrity: Intact..."</p> <p>On 10/22/14 at 4:55 PM, the DNS was interviewed regarding the Stage II Pressure Ulcers mentioned on the Care Plan for Resident #1. The DNS stated, "Oh no, does that say current pressure ulcers. [Resident's name] does not have any current open pressure ulcers and there are no dressings. We got them all healed in a short time." The DNS said, the Care Plan should have been updated to reflect the changes. The resident continued to be at high risk for pressure ulcers and so interventions were still in place, but the dressing had been discontinued.</p> <p>b) Resident #1's current October 2014 Care Plan was documented at the top of each page, as original date of 1/29/14 and modified date of 10/6/14. The resident's LTC Problems were: Functioning/Structural, Behavior, Communication, Bowel and Bladder, Injury, Depression, Symptoms-Pain, Nutrition, and Skin. The LTC Problems did not include the original dates the problems were identified and added to the Care Plan.</p> <p>There were no implementation dates on the Care Plan for the identified goals related to each LTC</p>	F 280			

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NAME OF PROVIDER OR SUPPLIER BEAR LAKE MEMORIAL SKILLED NURSING FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 164 SOUTH FIFTH STREET MONTPELIER, ID 83254		
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F 280	<p>Continued From page 8 problem.</p> <p>Resident #1's Care Plan Interventions for each problem had numerous interventions. None of the interventions included the dates of implementation.</p> <p>5. Resident #3 was admitted to the facility on 7/29/12 and then readmitted on 8/7/13, with diagnoses including legal blindness, altered mental Status, history of Cerebrovascular Accident (CVA), history of Transient Ischemic Attack, and a left ankle-foot deformity.</p> <p>Resident #3's current October 2014 Care Plan was documented at the top of each page with an original date of 1/29/14 and modified date of 10/15/14. The resident's LTC Problems were: Functioning/Structural, Bowel and Bladder, Incontinent, Cognitive Problems, Injury, Nutrition, Psychosocial, Psychotropic Drug, Senses, Skin, and Dehydration. The LTC Problems did not include the original dates the problems were identified and added to the Care Plan.</p> <p>There were no implementation dates on the Care Plan for the identified goals related to each LTC problem.</p> <p>Resident #3's Care Plan Interventions for each problem had numerous interventions. None of the interventions included the dates of implementation.</p> <p>6. Resident #5 was admitted to the facility on 3/31/09 and then readmitted on 9/4/09 and 6/18/11, with diagnoses including Chronic Migraines, Seizures, Status Post CVA, and Diabetes.</p>	F 280		

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F 280	<p>Continued From page 9</p> <p>Resident #5's current October 2014 Care Plan was documented at the top of each page, as original date of 1/31/14 and modified date of 10/24/14. The resident's LTC Problems were: Functioning/Structural, Behavior, Bowel and Bladder, Catheters, Gas Exchange Impaired, Injury, Nutrition, Psychosocial, Psychotropic Drug, Skin, and Symptoms-Pain. The LTC Problems did not include the original dates the problems were identified and added to the Care Plan.</p> <p>There were no implementation dates on the Care Plan for the identified goals related to each LTC problem.</p> <p>Resident #5's Care Plan Interventions for each problem have numerous interventions. None of the interventions included the dates of implementation.</p> <p>7. Similar findings regarding undated care plan problems and implementations were identified for Resident #7.</p> <p>On 10/22/14 at 12:40 PM, the DNS was interviewed regarding the dates of implementation for problems, goals, and interventions. The DNS stated, "My fault. I have been trying to put them on, but they may not be on the current Care Plans." The DNS said, the facility's computer program does not automatically list any dates for the residents' Care Plans problems, goals, and interventions other than at the top of the Care Plan which documented original dates and modify dates. The dates for each problem, goal, and intervention would have to be manually typed in each time.</p>	F 280		

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F 280	Continued From page 10 On 10/22/14 at 7:13 PM, the AIT and DNS were informed of the concerns for dates on the Care Plans. No additional information was provided by the facility.	F 280		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure Care Plan interventions were followed for resident transfers. This affected 1 of 9 (#3) sampled residents. This deficient practice could have resulted in harm for Resident #3, when transfers were performed without leading with his right side. Findings included: Resident #3 was admitted to the facility on 7/29/12 and then readmitted on 8/7/13, with diagnoses including legal blindness, altered mental status, history of Cerebrovascular Accident (CVA), history of Transient Ischemic Attack (TIA), history of benign Neoplasm of Brain, and left ankle-foot deformity. The resident's annual MDS dated 7/15/14, documented BIMS score as 7-Severely Impaired.	F 309	F-309: Corrective actions accomplished for residents affected by the practice include: Staff members were instructed in the proper procedure for transferring resident #3 immediately and will receive further instruction at an inservice on 11-13-14. All residents have the potential for harm if staff members fail to follow interventions that have been care planned to assure their safety. Staff members will be accountable to adhere to the care plans for individual residents. Measures that will be put into place to assure the practice does not recur include: Staff members will be alerted to care plan revisions and updates through use of a messaging system that provides and alert when they log on to the system. Resident care monitoring will be done randomly to assure adherence to care plans. Audits will be performed by the DNS, Social Worker, RNA, or other Licensed Nurse weekly x 1 month then monthly x 3 months, then quarterly thereafter.	11-13-14

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F 309	<p>Continued From page 11</p> <p>The resident's quarterly MDS assessment dated 10/7/14, documented the following: *Vision-Severely impaired; *Bed Mobility-Total dependence and two plus person assist; *Transfer-Total dependence and two plus person assist; and, *Balance During Transitions and Walking-Moving from seated to standing position and moving on and off toilet: Not steady, only able to stabilize with staff assistance.</p> <p>Resident #3's October 2014 Care Plan documented, LTC Problem: "Functioning/Structural...Self care deficit: Needs extensive assistance with ADLs." Interventions: "...Needs extensive two person assistance for transfers. Use gait belt. He is unable to use his left arm effectively to use walker. Use stand pivot transfer technique...unable to maintain balance...Apply brace to his left leg for transfers due to risk of ankle turning resulting in fracture. Cue him to step with right leg for transfers."</p> <p>LTC Problem: "Injury Risk..." Interventions: "...two-person assistance for transfers... Transfer to the right d/t [due to] inability to bear weight on left leg..."</p> <p>On 10/22/14 at 1:00PM, CNA #9 and CNA #10 were observed to transfer Resident #3 from the commode to the recliner. The resident was seated on the bedside commode and had a brace on the left leg. The CNAs placed a gait belt around him. The CNAs had the bedside commode at a 90 degree angle on the right side of the recliner. Each CNA got under an arm and a hold of the gait belt, then instructed the resident</p>	F 309			

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F 309	Continued From page 12 to stand. The resident stood with their help and then was instructed to pivot. The resident was pivoted to the left and then let slowly down into his recliner. The surveyor asked the CNAs if the resident's Care Plan addressed the left leg brace and how the resident should be transferred. CNA #10 stated, "The brace needs to be on for transfers and when he is up in the wheelchair. We were backwards. We should have been transferring him with his good leg. On 10/22/14 at 7:12 PM, the AIT and DNS were informed of the concerns with following the Care Plan on transfers. No additional information has been provided.	F 309		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and	F 329	F-329: Corrective actions that will be accomplished for residents affected practice include: Nursing staff was re-educated in the need for monitoring and documenting the effectiveness of PRN medications for residents #4 and 7 immediately and will receive further instruction at an inservice on 11-13-14. All residents who receive PRN medications are at risk for harm if monitoring and documentation of the effectiveness of medications is not done. Nursing staff will assess the reasons for the medication, monitor for effectiveness and document the results in the resident's clinical record. Measures that will be put into place to ensure the practice does not recur include: Nursing staff will be required to document the reason(s) for the PRN	

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F 329	<p>Continued From page 13</p> <p>behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility failed to ensure 2 of 9 sample residents (#s 4 and 7) were free from unnecessary medications when PRN (as needed) medications were not consistently monitored for efficacy. The failure placed the residents at risk for overmedication and/or unrelieved anxiety and pain. Findings include:</p> <p>1. Resident #4 was admitted to the facility in 2012 with multiple diagnoses which included anxiety related to Alzheimer's dementia.</p> <p>The resident's annual MDS assessment, dated 8/26/14, coding included severe cognitive deficit, usually able to understand others and usually understood by others, vocal complaints and facial expressions of pain, indicators of pain or possible pain observed 1 to 2 of the last 5 days, and received antianxiety medication 7 of the last 7 days.</p> <p>On 10/21/14 at 2:00 p.m., when asked for the resident's current physician's order, the DNS provided an undated Nursing Orders Report and Physician's Medication Report which she said were the "active, current orders."</p> <p>The resident's Physician's Medication Report</p>	F 329	<p>(Continued from page 13)</p> <p>Medications and to assess the effectiveness of the medication and document the results in the resident's EMAR. Nurses will be required to review the EMAR to ensure that all PRN medications that have been given are addressed prior to completion of their shift.</p> <p>Audits will be performed by the DNS weekly x 4 weeks then monthly thereafter.</p>	11-13-14

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F 329	<p>Continued From page 14 included orders Ativan 0.25 milligrams (mg) 2 times/day if needed (PRN) for anxiety and Tramadol 50 mg every 4 hours if needed for pain.</p> <p>The resident's MAR, dated 10/1/14 to 10/21/14, contained documentation that PRN Ativan and Tramadol were not consistently monitored for effectiveness as follows: * Ativan - 4 of 7 administrations, or 57% of the time; and, * Tramadol - 7 of 12 administrations, or 58% of the time.</p> <p>On 10/23/14 at 3:00 p.m., when asked about the efficacy of the PRN antianxiety and analgesic medications, the DNS confirmed the documentation was inconsistent. She added, "It's not in the progress notes either."</p> <p>2. Resident #7 was admitted to the facility on 9/9/14 with diagnoses of mental status change, behavior outbursts, and Alzheimer's dementia.</p> <p>The resident's 9/4/14 History and Physical documented, "...has been followed extensively in the outpatient setting for worsening dementia...recently he has become significantly more agitated...He [resident] suddenly started not to recognize and actually got in to a physical altercation with him [son]...also has become more physical with his wife...grabbing her around the neck, being up and down at night, changing clothes repeatedly..."</p> <p>The resident's 9/9/14 Discharge Summary documented, "...has required Ativan...to control agitation...fairly stable with this point...overall medically stabilized..."</p>	F 329		
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F 329	Continued From page 15 The resident's 9/9/14 Physician's Medications Report included an order for lorazepam (generic Ativan) 0.5 milligrams by mouth every 8 hours PRN anxiety, agitation. The admission MDS assessment, dated 9/15/14, documented the resident sometimes understood others and was sometimes understood by others, had severe cognitive impairment, and he received antianxiety medication for 7 of the last 7 days. The resident's MAR, for 9/9/14 to 9/23/14, and Progress Notes for the same time frame, contained documentation that PRN Ativan was not consistently monitored for effectiveness 20 of 49 administrations, or 40.8% of the time. On 10/23/14 at 8:00 p.m., the AIT and DNS were informed that PRN medications were not consistently monitored for efficacy. The facility did not provide any of information regarding the issue.	F 329		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by:	F 371	F-371: Corrective actions that will be accomplished for those residents affected by the practice include: The meat slicer was broken down and cleaned immediately. The ice machine was cleaned immediately. Food items in the fridge that were not labeled and dated were discarded immediately. Any person who eats food prepared in the kitchen has the potential for harm if food is contaminated. Dietary staff will assure cleaning is done according to established cleaning schedules.	

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F 371	<p>Continued From page 16</p> <p>Based on observation and staff interview, it was determined the facility failed to ensure the slicer blade and ice machine were clean and food in the refrigerator was marked and dated. This failed practice created the potential for contamination of food and exposed 9 of 9 sample residents (#s 1-9) and all residents who ate food prepared in the facility's kitchen to potential sources of disease causing pathogens. Findings included:</p> <p>On 10/20/14 at 2:40 p.m., during the initial tour of the kitchen with the Dietary Manager (DM) in attendance, the following was found:</p> <ul style="list-style-type: none"> * Three flecks of a light tan substance was on the backside of the slicer blade. The DM identified the flecks as "meat" and said the slicer was "used yesterday." The DM said the slicer blade would be cleaned right away. * A sticky, rust colored substance covered 1 and 1/2 inches of the bottom left horizontal surface of the door frame opening into the ice machine. And, a loose grout or gravel like substance covered 1 inch of the left side of a narrow ledge just above the door frame opening into the ice machine. The DM acknowledged both substances and said they would be cleaned up right away. * A regular size "to go" box/container with spaghetti and meatballs and corn (off the cob) was unmarked and undated in the front refrigerator. The DM removed the "to go" box/container from the refrigerator and said it should have been marked and dated. <p>The 2009 FDA Food Code, Chapter 4, Part 4-6, Cleaning of Equipment and Utensils, Subpart 601.11 Equipment, Food-Contact Surfaces, Nonfood Contact Surfaces, and Utensils, (A), indicated, "Equipment food-contact surfaces and</p>	F 371	<p>(Continued from page 16)</p> <p>Measures that will be put into place to assure the practice does not recur include: Staff members will watch a training video on how to properly use and clean the slicer at an inservice on 11-12-14. Staff members will be reminded of the importance of labeling and dating items placed in the refrigerator at an inservice on 11-12-14. Staff members will be re-educated on how to properly clean the ice machine at an inservice on 11-12-14.</p> <p>The dietary manager will monitor the cleaning schedule weekly to assure cleaning is being done. The Dietary manager will do regular checks to assure the slicer is clean and items in the refrigerator s are labeled and dated. Audits will be done twice per week.</p>	11-13-14

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F 371	Continued From page 17 utensils shall be clean to sight and touch." Subpart 4-602.11 indicates, "(A) Equipment food-contact surfaces and utensils shall be cleaned:...(5) At any time during the operation when contamination may have occurred."	F 371		
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	F 431	F-431: Corrective actions that will be accomplished for residents affected by the practice include: Expired medical supplies were removed and discarded immediately. All residents have the potential for decreased efficacy if expired medications/ biologicals are used. Measures that will be implemented to ensure the practice does not recur include: The medication room will be monitored weekly by a designated staff member (the person responsible for ordering supplies). Any expired medications/biological supplies will be discarded and replaced. The DNS or Pharmacist will complete audits weekly x 2 weeks then monthly thereafter.	11-13-14

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F 431	<p>Continued From page 18</p> <p>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 expired medications and biological supplies were removed from the medication room. This was true for 1 of 1 medication rooms checked for expired medications and supplies. This created the potential for decreased efficacy for any resident who could have received the expired medication or exposure to expired biological supplies. Findings included:</p> <p>On 10/23/14 at 8:50 AM, an inspection of the Medication Room revealed expired medications and biologicals. They were as follows: *1 -14 French Self Cath - Expired 8/2009; *1 box of Povidone-Iodine Prep Pads - Expired 6/2014; *2 bottles of Rubbing Alcohol - both expired 6/2014; *1 bottle of Adapt Lubricating Deodorant - expired 6/2011; *1 box of Alcohol Swabsticks - Expired 11/2010; and, *3 IV needles: 2 of the 24 gauge 0.75 inch needle and 1 of the 22 gauge 1 inch needle.</p> <p>LN #3 was asked to read the dates of the expired medications and biological supplies and agreed</p>	F 431			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135070	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/24/2014
NAME OF PROVIDER OR SUPPLIER BEAR LAKE MEMORIAL SKILLED NURSING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 164 SOUTH FIFTH STREET MONTPELIER, ID 83254	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 19 the items were all expired. The LN stated in regards to the IV catheters, "We don't use those anymore, so don't know why they are in there." On 10/23/14 at 8:00 PM, the Administrator in Training and DNS were informed of the expired medications and labeling concerns. No additional information was provided that could resolve the issues.	F 431		
F 441 SS=D	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	F 441	F-441: Corrective actions that will be accomplished for residents affected by the practice include: A safety pin was placed to the back of the wheelchair of resident #2 to hang the catheter bag at a level that prevents contact with the floor. C.N.A.'s and Nursing staff will be re-educated on the importance of hand hygiene in preventing the spread of infection at an inservice on 11-13-14. All residents with a catheter have the potential for infections if catheter bags come into contact with the floor. All residents have the potential for infections if hand hygiene is not practiced consistently. All staff members are required to observe universal precautions, including appropriate hand hygiene before and after providing resident care and between tasks. Catheter bags will be secured in a manner that prevents contact with the floor.	

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NAME OF PROVIDER OR SUPPLIER BEAR LAKE MEMORIAL SKILLED NURSING FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 164 SOUTH FIFTH STREET MONTPELIER, ID 83264		
(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 441	<p>Continued From page 20 hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, it was determined the facility failed to keep a urinary drainage bag in a privacy cover off the floor and to ensure staff completed hand hygiene after incontinence care for 3 of 9 sample residents (#s 2, 4, and 6). The failures created the potential for the residents to develop infections from cross contamination. Findings Included:</p> <p>1. Resident #2 was admitted to the facility in 2010 with multiple diagnoses which included neurogenic bladder and Parkinson's disease.</p> <p>The resident's annual MDS assessment, dated 7/29/14, coding included moderate cognitive impairment and extensive assistance for toileting and hygiene.</p> <p>The resident's care plan included risk for infections related to an indwelling Foley (name brand) urinary catheter.</p> <p>On 10/21/14 at 2:00 p.m., when asked for the resident's current physician's order, the DNS stated the Nursing Orders Report and the Physician's Medication Report were the "active,</p>	F 441	<p>(Continued from page 20)</p> <p>Measures that will be put into place to assure the practice does not recur include: Random hand washing surveys will be performed to assure compliance with hand hygiene. A hook will be placed to the backs of wheelchairs (of residents with catheters) for use to secure the bag at a level that prevents the catheter bag from coming into contact with the floor.</p> <p>The DNS, ADNS or other Licensed nurse will perform audits daily x 2 weeks then weekly x 1 month then monthly thereafter.</p>	11-13-14

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NAME OF PROVIDER OR SUPPLIER BEAR LAKE MEMORIAL SKILLED NURSING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 164 SOUTH FIFTH STREET MONTPELIER, ID 83254		
(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)	(X6) COMPLETION DATE	
F 441	<p>Continued From page 21</p> <p>current orders." The resident's Nursing Orders Report included an order for a Foley and to change it 2 times per month.</p> <p>The resident's urinary drainage bag in a privacy bag was observed to be in contact with the floor on:</p> <ul style="list-style-type: none"> * 10/21/14 at 11:40 a.m. - the resident was in her wheelchair (w/c) in her room; and, * 10/21/14 at 12:05 p.m. - the resident was propelled in her w/c to the dining room. <p>On 10/22/14 at 10:30 a.m., during an interview, the Infection Control Nurse (ICN) was asked if privacy bags used to cover urinary drainage bags were impermeable. The ICN said she did not know. When informed a urinary drainage bag in a privacy bag had been observed in contact with the floor, the ICN said she thought the privacy bags were made of "heavy canvas." The ICN said she would ask the DNS about it.</p> <p>On 10/22/14 at 11:45 a.m., during a skin check by LN #4 with assistance by the DNS and MDS Coordinator, the resident's urinary drainage bag in a soft cloth privacy bag was observed as it fell to the floor when 2 of the nurses stood the resident up from her w/c. The bag stayed on the floor while LN #4 tried, without success, to secure a safety pin to the back of the resident's w/c. After a minute, the MDS Coordinator took over and secured the safety pin to the w/c back. When informed the urinary drainage bag in the privacy bag was on the floor, the DNS stated, "We don't want it on the floor." The MDS Coordinator picked up the drainage bag in the privacy bag and suspended it from the safety pin at the back of the resident's w/c.</p>	F 441			

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NAME OF PROVIDER OR SUPPLIER BEAR LAKE MEMORIAL SKILLED NURSING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 184 SOUTH FIFTH STREET MONTPELIER, ID 83254	
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F 441	<p>Continued From page 22</p> <p>On 10/22/14 at 12:20 p.m., when asked about urinary drainage bags in privacy bags in contact with the floor, the DNS said she had "noticed it too" and, "That's why we added a safety pin to back of the wheelchair."</p> <p>2. Resident #6 was admitted to the facility in 2012 with diagnoses that included debility and weakness.</p> <p>The resident's most recent quarterly MDS assessment, dated 9/6/14, coding included intact cognition, extensive 2 person assistance for transfers/toileting/hygiene, and always incontinent of bladder.</p> <p>The resident's self care deficit care plan interventions included, "Needs extensive two person assistance for toileting...unable to maintain balance to self-perform peri-care or to adjust her clothing after toilet use...uses the BSC [bedside commode]during the day..."</p> <p>On 10/21/14 at 11:25 a.m., CNA #s 7 and 8 were observed as they assisted the resident to use a BSC in her room. After that, CNA #8 took the resident out of her room in her wheelchair. However, CNA #8 did not wash or sanitize her hands before she left the resident's room.</p> <p>On 10/21/14 at 11:40 a.m., CNA #8 was informed of the aforementioned observation and asked about hand hygiene. The CNA stated, "Well, I did before I went in [the resident's room]." When asked if she performed hand hygiene after she assisted the resident with toileting, the CNA stated, "No. Sorry." The CNA sanitized her hands after that.</p>	F 441		

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NAME OF PROVIDER OR SUPPLIER BEAR LAKE MEMORIAL SKILLED NURSING FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 164 SOUTH FIFTH STREET MONTPELIER, ID 83254
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F 441	<p>Continued From page 23</p> <p>3. Resident #4 was admitted to the facility in 2012 with multiple diagnoses which included anxiety related to Alzheimer's dementia.</p> <p>The resident's annual MDS assessment, dated 8/26/14, coding included severe cognitive deficit, usually able to understand others and to be understood by others, extensive assistance for all ADLs except eating, and frequent urinary incontinence.</p> <p>The resident's self care deficit care plan interventions included, "Needs extensive 1-2 person assistance for toilet use. She is unable to self perform peri care or to adjust her clothing after toilet use."</p> <p>On 10/22/14 at 10:45 a.m., CNAs #5 and #6 were observed as they propelled the resident in her wheelchair (w/c) into a restroom across the hall from the dining room. CNA #6 removed the resident's oxygen (O2) nasal cannula from her nose, the CNAs stood the resident up, and with bare hands CNA #6 pulled down the resident's pants and pull-up and removed the incontinence liner and put it in the trash. After the CNAs transferred the resident onto the toilet, CNA #6, who was still bare handed and had not washed or sanitized her hands, reapplied the O2 nasal cannula in the resident's nostrils then opened the door and left the room.</p> <p>On 10/22/14 at 10:50 a.m., when informed of the aforementioned observation, CNA #6 stated, "I thought about that." The CNA confirmed she had not worn gloves when she assisted the resident with toileting or performed any type of hand hygiene before she handled the resident's O2 nasal cannula, touched the door handle, and left</p>	F 441		
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NAME OF PROVIDER OR SUPPLIER BEAR LAKE MEMORIAL SKILLED NURSING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 164 SOUTH FIFTH STREET MONTPELIER, ID 83254	
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F 441	Continued From page 24 the room.	F 441		
F 514 SS=D	<p>On 10/23/14 at 8:00 p.m., the AIT and DNS were informed of the infection control issue. The facility did not provide any other information regarding the issues.</p> <p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE</p> <p>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.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to maintain accurate and complete clinical records for each resident. This was true for 2 of 10 sample residents (#s 2 & 3). This deficient practice increased the risk for medical decisions to be based on incomplete or inaccurate information and increased the risk for complications due to inappropriate care and interventions. Findings included:</p> <p>1. Resident #2 was admitted to the facility in 2010</p>	F 514	<p>F-514: Corrective action accomplished for residents affected by the practice include: Nursing staff was reminded of the importance of documenting treatments (catheter change for resident #2) in the resident's EMR. Nursing staff was also reminded of the need to assure that student nurses provide appropriate documentation. The medication information for resident #3 was updated by pharmacy to reflect the correct information on the label.</p> <p>All residents are at risk for medical decisions to be made based on incomplete or inaccurate information. All residents are at risk for complications d/t inappropriate care and interventions.</p> <p>Nursing staff will ensure that treatments performed will be documented in the resident's treatment record (MedAct). Pharmacy will ensure that</p>	

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F 514	<p>Continued From page 25 with multiple diagnoses which included neurogenic bladder and Parkinson's disease.</p> <p>The resident's annual MDS assessment, dated 7/29/14, coding included moderate cognitive impairment and extensive assistance for toileting and hygiene.</p> <p>The resident's care plan included risk for infections related to an indwelling Foley (name brand) urinary catheter.</p> <p>On 10/21/14 at 2:00 p.m., when asked for the resident's current physician's order, the DNS provided an undated Nursing Orders Report and Physician's Medication Report which she said were the "active, current orders." The resident's Nursing Orders Report included orders for a Foley catheter and to change it 2 times per month.</p> <p>On 10/22/14 at 10:35 a.m., the DNS was asked to provide documentation of resident's Foley catheter changes for September and October 2014. The DNS reviewed the resident's electronic medical record and found documentation the catheter was changed only on 9/12/14. The DNS said she would look more and get back with the surveyor.</p> <p>On 10/22/14 at 5:30 p.m., the DNS provided documentation the resident's catheter was changed on 9/29/14. The DNS said she was still looking for documentation in October.</p> <p>On 10/23/14 at 7:35 p.m., the DNS said she had not found any documentation that the resident's catheter was changed in October. At then, the MDS Coordinator joined the interview and said a</p>	F 514	<p>(continued from page 25)</p> <p>medications are labeled correctly.</p> <p>Measures that will be put in place to assure the practice does not recur include: Nursing staff will be required to review each resident's treatment record (MedAct) prior to the completion of their shift to ensure that scheduled treatments are performed and documented appropriately. Nursing staff will be required to verify that medication labeling matches the EMAR when new orders are received and notify Pharmacy if discrepancies are observed.</p> <p>Audits will be performed by the DNS or other Licensed Nurse daily x 2 weeks then weekly x 4 weeks then monthly thereafter.</p>	11-13-14

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NAME OF PROVIDER OR SUPPLIER BEAR LAKE MEMORIAL SKILLED NURSING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 164 SOUTH FIFTH STREET MONTPELIER, ID 83254		
(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 514	<p>Continued From page 26</p> <p>student nurse changed the catheter in October. A few moments later, the MDS Coordinator provided a form from a university Practical Nursing Program which documented the catheter was changed on 10/14/14 by a student nurse and under supervision of a nurse. The DNS and MDS Coordinator confirmed that the documentation was not in the resident's clinical record. The DNS stated, "It should be documented in her record." The facility did not provide any other information regarding the issue.</p> <p>2. Resident #3 was admitted to the facility on 7/29/12 and then readmitted on 8/7/13, with diagnoses including legal blindness, altered mental status, seizures, history of Cerebrovascular Accident (CVA), history of Transient Ischemic Attack, and a left ankle-foot deformity.</p> <p>Resident #3's October 2014 Physician's Medications Report documented, "Lamotrigine 100MG Tab... 75 MG Orally at Bedtime: Seizures."</p> <p>The resident's 10/1/14 to 10/21/14 MAR documented, "Lamotrigine 75MG Orally at Bedtime: Seizures", being given 10/1/14 through 10/20/14.</p> <p>Resident #3's October blister pack label on the front had documented, "...75MG Orally at Bedtime: Seizures Lamotrigine 100MG Tab." The blister pack contained 1/2 and 1/4 of a tablet per day. The back of the blister pack had written on it, "Item Lamictal, Strength 100MG X 3/4=75MG..."</p> <p>The resident's medical record contained an email dated 4/30/14 3:13 PM, from the DNS to</p>	F 514			

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F 514	<p>Continued From page 27</p> <p>(Physician's Name) regarding the discussion of Lamotrigine during the resident's family care conference.</p> <p>*This email documented, "...[Resident #3's mother's name] also would like you to consider using non-generic Lamictal (He is getting Lamotrigine). She says it is documented that he can only have the Lamictal. I have noted quite a bit of jerking, especially in the mornings at breakfast..."</p> <p>*In the response from (Resident's Physician) dated 4/30/14 10:01 PM, it was documented, "I thought we had already changed to brand name Lamictal but obviously I didn't. I do recall that being an issue in the past so see what we need to do to get it..."</p> <p>*A handwritten documentation signed by the DNS dated 5/1/14, "Spoke c [with] [Physician's Name] et [and] pharmacy about Lamictal concerns. Pharmacy verified that res [resident] is receiving brand name Lamictal. Lamotrigine stated on E-Mar incorrect..."</p> <p>On 10/21/14 at 2:00 p.m., when asked about a resident's current physician's order, the DNS stated the Nursing Orders Report and the Physician's Medication Report were the "active, current orders." The DNS said the Physician's Medication Report would be the discharge summary for a resident. Resident #3's current Physician's Medication Report documented the resident was receiving generic Lamotrigine and not brand name Lamictal.</p> <p>On 10/23/14 at 5:25 PM, in regards to the label and the MAR documentation having listed the resident's medication as the generic Lamotrigine, the facility's Pharmacist stated, "When the tech was entering they must not have keyed it to have</p>	F 514		

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F 514	Continued From page 28 both [generic and brand drug names]on the computer. He's our first patient to need brand name. On the pharmacy side, it shows that it's Lamictal. I will go and update it, so it shows on the label that it's brand name." On 10/23/14 at 8:00 PM, the Administrator in Training and DNS were informed of the concerns. No additional information was provided by the facility.	F 514		

Bureau of Facility Standards

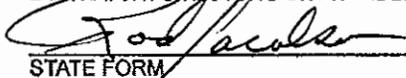
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001030	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/24/2014
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NAME OF PROVIDER OR SUPPLIER
BEAR LAKE MEMORIAL SKILLED NURSING F/

STREET ADDRESS, CITY, STATE, ZIP CODE
**164 SOUTH FIFTH STREET
MONTPELIER, ID 83254**

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C 000	16.03.02 INITIAL COMMENTS The following deficiencies were cited during the State licensure survey of your facility conducted October 20, 2014 through October 24, 2014. The surveyors who conducted the survey were: Linda Kelly, RN, Team Coordinator, and Linda Hukill-Neil, RN.	C 000		
C 325	02.107,08 FOOD SANITATION 08. Food Sanitation. The acquisition, preparation, storage, and serving of all food and drink in a facility shall comply with Idaho Department of Health and Welfare Rules, Title 02, Chapter 19, "Rules Governing Food Sanitation Standards for Food Establishments (UNICODE)." This Rule is not met as evidenced by: Refer to F371 as it related to sanitary conditions in the kitchen.	C 325	See POC for F-371	
C 411	02.120,05,k All Resident Rooms Numbered k. All patient/resident rooms shall be numbered. All other rooms shall be numbered or identified as to purpose. This Rule is not met as evidenced by: Based on observations and staff interview, the facility failed to ensure nine rooms in the facility were labeled. This had the potential to affect the residents who resided in the facility, staff, and any visitors to the facility. Findings included: On 10/23/14 at 10:15 AM, during the tour of the facility with maintenance, the following rooms were observed to not have any identification on them:	C 411	Signage will be placed to identify the contents of the Nourishment Room, Activity Supply Room, Nurses Lounge, Medication Room, Medical Record Storage/ Wheelchair Room, Clean Linen, Soiled Utility, Data Room and Storage Room. Any residents, visitors or new staff would not know what was behind each door.	

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



TITLE

Admin

(X8) DATE

11-14-14

[Type a quote from the document or the summary of an interesting point. You can position the text box anywhere in the document. Use the Drawing Tools tab to change the formatting of the pull quote text box.]

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001030	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/24/2014
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NAME OF PROVIDER OR SUPPLIER BEAR LAKE MEMORIAL SKILLED NURSING F	STREET ADDRESS, CITY, STATE, ZIP CODE 164 SOUTH FIFTH STREET MONTPELIER, ID 83254
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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C 411	<p>Continued From page 1</p> <ul style="list-style-type: none"> *Nourishment Room; *Activity Supply Room in the Dining Room; *Staff Lounge Room; *Medication Room; *Medical Record Overflow & Wheelchair Storage Room; *Clean Linen Room; *Soiled Utility Room; *Data Room; and, *Storage Room (contained water softener & misc. equipment). <p>The maintenance staff unlocked if needed and opened every unlabeled door, so the surveyor could see what each room contained. The maintenance staff agreed there was no labeling the purpose of each room and it would be impossible for residents, visitors or new staff to know what was behind each closed door.</p> <p>On 10/23/14 at 8:00 PM, the Administrator in Training (AIT) and DNS were informed of the issue. No additional information was provided.</p>	C 411	<p>(continued from page 1)</p> <p>Measures that will be taken to assure the practice does not recur include placing signage on all doors in the SNF to identify the contents/purpose of the room.</p> <p>The Activity Director will perform audits monthly.</p> <p>See POC for F-441</p>	11-13-14
C 644	<p>02.150,01,a,i Handwashing Techniques</p> <p>a. Methods of maintaining sanitary conditions in the facility such as:</p> <p>i. Handwashing techniques.</p> <p>This Rule is not met as evidenced by: Refer to F441 as it related to hand hygiene.</p>	C 644	See POC for F-441	
C 671	<p>02.150,03,b Handling Dressings, Linens, Food</p> <p>b. Proper handling of dressings, linens and food, etc., by staff.</p> <p>This Rule is not met as evidenced by:</p>	C 671	See POC for F-441	

Bureau of Facility Standards

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NAME OF PROVIDER OR SUPPLIER **BEAR LAKE MEMORIAL SKILLED NURSING F** STREET ADDRESS, CITY, STATE, ZIP CODE **164 SOUTH FIFTH STREET MONTPELIER, ID 83254**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 671	Continued From page 2 Refer to F441 as it related to a urinary drainage bag in a privacy bag on the floor.	C 671		
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: Refer to F280 as it related to revising/updating care plans.	C 782	See POC for F-280	
C 784	02.200,03,b Resident Needs Identified b. Patient/resident needs shall be recognized by nursing staff and nursing services shall be provided to assure that each patient/resident receives care necessary to meet his total needs. Care shall include, but is not limited to: This Rule is not met as evidenced by: Refer to F246 as it related to accomodations during meals. Refer to F309 for not following Care Plan in transfers.	C 784	See POC for F-246 See POC for F309 <i>Per TC w/ administration 12/5/14 at 10:36 AM. Ashford</i>	
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 for removal of expired medications	C 821	See POC for F-431	

Bureau of Facility Standards

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NAME OF PROVIDER OR SUPPLIER BEAR LAKE MEMORIAL SKILLED NURSING F,	STREET ADDRESS, CITY, STATE, ZIP CODE 164 SOUTH FIFTH STREET MONTPELIER, ID 83254
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C 821	Continued From page 3 and biologicals.	C 821		
C 856	02.201,04,c Documentation of Use and Results c. Reasons for administration of a PRN medication and the patient's/resident's response to the medication shall be documented in the nurse's notes. This Rule is not met as evidenced by: Refer to F329 as it related to the efficacy of as needed medications.	C 856	See POC for F-329	
C 879	02.203 PATIENT/RESIDENT RECORDS 203. PATIENT/RESIDENT RECORDS. The facility maintains medical records for all patients/residents in accordance with accepted professional standards and practices. This Rule is not met as evidenced by: Refer to F514 regarding maintenance of accurate medical records.	C 879	See POC for F-514	