



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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

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

**CERTIFIED MAIL: 7012 3050 0001 2125 6003**

November 13, 2014

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

Provider #: 135004

FILE COPY

Dear Mr. Johnson:

On **October 28, 2014**, we conducted an on-site follow-up revisit to verify that your facility had achieved and maintained compliance. We had presumed, based on your allegation of compliance, that your facility was in substantial compliance as of **October 17, 2014**. However, based on our on-site follow-up revisit conducted **October 28, 2014**, we found that your facility is not in substantial compliance with the following participation requirements:

**F280 -- S/S: D -- 42 CFR §483.20(d)(3), 483.10(k)(2) -- Right to Participate Planning Care-Revise CP**

**F323 -- S/S: D -- 42 CFR §483.25(h) -- Free of Accident Hazards/Supervision/Devices**

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. **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 copy of the Post-Certification Revisit Reports, Form CMS-2567B, listing deficiencies that have been corrected is enclosed.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **November 26, 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*.

As noted in the letter of **October 8, 2014**, following the **Federal Comparative** survey of **September 25, 2014**, by a survey team from the Centers for Medicare and Medicaid Services (CMS), a Denial of Payment for New Admissions is effective for new Medicare and Medicaid admissions if the facility is not in substantial compliance on or after **November 21, 2014**, and termination of the provider agreement on **February 21, 2015**, if substantial compliance is not achieved by that time.

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

STATE ACTIONS effective with the date of this letter (**November 13, 2014**): None

If you believe the 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

Craig A. Johnson, Administrator  
November 13, 2014  
Page 3 of 3

Elder Street, Post Office Box 83720; Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option #2; 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.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You may also contest scope and severity assessments for deficiencies, which resulted in a finding of SQC or immediate jeopardy. 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 **November 26, 2014**. If your request for informal dispute resolution is received after **November 26, 2014**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the on-site follow-up revisit. If 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 at (208) 334-6626.

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: 11/13/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135004	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  R 10/28/2014
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NAME OF PROVIDER OR SUPPLIER  BOUNDARY COUNTY NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 6640 KANIKSU STREET BONNERS FERRY, ID 83805
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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}	INITIAL COMMENTS  The following deficiencies were cited during the follow-up recertification survey of your facility conducted on 10/28/14.  The surveyors conducting the survey were: Susan Gollobit, RN, Team Coordinator, and Lorraine Hutton, RN.  Survey definitions: BIMS = Brief Interview for Mental Status CNA = Certified Nurse Aide CNO = Chief Nursing Officer LN = Licensed Nurse MDS = Minimum Data Set F 280 483.20(d)(3), 483.10(k)(2) RIGHT TO SS=D 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, 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.	{F 000}	All dates indicated are for the year 2014. Disclaimer: Plan of correction if being submitted in accordance with specific regulatory requirements. It shall not be construed as an admission of any deficiency cited. <i>RECEIVED</i> <i>NOV 21 2014</i> <i>FACILITY STANDARDS</i> F280 11/20/14 Enclosures: #1 Resident - Safe Smoking and Impaired Skin Integrity Care Plans #2 Smoking Log #3 Safe Smoking Care Plan addendum sign-in sheet #4 Resident #5 Room check #5 Bath scheduling  F323- #1 Room Audit for hazardous items 10/28/14, 11/17/14	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE CEO	(X6) DATE 11/20/2014
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting provided 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 280	Continued From page 1  This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview and review of the facility's Plan of Correction (POC) for the State Agency's survey of 8/21/14 and the Federal Monitoring Survey of 9/25/14, it was determined the facility failed to revise the care plan for 1 of 4 (#1) residents reviewed. Failure to ensure the care plan was updated to reflect the resident's current status related to smoking placed the resident at risk to not have his needs met. Findings included:  The surveys of 8/21/14 and 9/25/14 both identified that Resident #1 had sustained cigarette burns as a result of unsafe smoking habits. The facility's POC for the survey of 9/25/14 included an "Action Plan" with an intervention for, "Resident will be provided with choice of electronic cigarette [E-cigarette] or tobacco cigarette. If resident requests electronic cigarette, staff to escort and set-up including smoking apron." The facility documented it would "Identify and Monitor resident's skin for burns" with an intervention for "Skin assessment to be completed weekly and with bathing."  Resident #1 was admitted to the facility with multiple diagnoses including chronic pain, neurogenic bladder, quadriplegia, c-spine injury, and spasticity.  The Quarterly MDS, dated 6/10/14, coded the resident was cognitively intact with a BIMS score of 13.  The resident's care plan documented the	F 280	F280: 11/20/14 <u>Root Cause:</u> Care Plan Revision process was not followed to reflect residents' current smoking status and smoking set-up. Facility plan of correction was not adequately communicated to staff. <u>Corrective Action: Resident#1</u> 1. Care Plan updated to reflect current smoking status and smoking set-up. 2. Skin assessment schedule updated in care plan to be weekly and on bath day Licensed Staff (NOC shift to be complete) <u>Identification of Residents with potential to be affected by deficient practice:</u> 11/20/14  All resident care plans will be audited completion and accuracy using Comprehensive Assessment trigger analysis.  <u>Systemetic Changes:</u> 11/20/14 <u>Trigger Analysis</u> will be utilized to identify all potential care plan problems related to MDS admission, annual and significant change of status assessments to insure that all triggers, new interventions and updates are adequately reflected in the resident's care plan.		

*[Handwritten Signature]* 11/20/14

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F 280	Continued From page 2 following: -Self Care Deficit, with an intervention dated 8/31/11, the resident was able to smoke independently after set up with adaptive device and protective cover, -Potential for Impaired Airway, with an intervention dated 2/27/12, smoking cessation and E cigarettes options have been offered and refused. -Potential for Injury/Burns, with interventions dated 9/24/14, resident is unsafe to smoke tobacco cigarette independently; staff to...supervise resident while smoking tobacco cigarette. Document which type of cigarette - E cigarette or tobacco lit cigarette. Additional Interventions included: *The resident could choose between an E cigarette and tobacco, *The resident could smoke the E cigarettes alone after being escorted out and set up by a staff, and *A black smoking apron was to be used during supervised tobacco smoking times.  The E-Cigarette Education Syllabus, dated 9/27/14, documented the resident was to wear "his smoking cape" with a real cigarette. The education did not include the resident was to wear the smoking cape (apron) when he smoked an E cigarette.  The care plan did not document the resident was to wear the smoking apron when smoking the E cigarette. Further, the care plan did not document the intervention for skin assessments to be completed weekly and with bathing related to burns to the resident's skin as identified in the POCs. Refer to F323, example 1 for additional details regarding the skin checks	F 280	<u>Quality Monitoring:11/20/14</u> All MDS Assessments completed will be audited to ensure that all triggers, new interventions and updates are accurately included in the residents care plan and within the RAI Care Plan completion time frame. <u>Audit start date: 11/18/14</u> <u>Monitoring Frequency:Weekly</u> per MDS schedule <u>Responsible Party:</u> CNO/Designee		

*[Handwritten Signature]* cco 11/20/14

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F 280	Continued From page 3 On 10/28/14 at 2:25 PM, the CNO was asked about the 8/31/11 and 2/27/12 care plan interventions. The CNO stated they should have been taken off the care plan.  On 10/28/14 at 2:50 PM, Resident #1 stated he did not use the apron when he smoked an E-cigarette.  On 10/28/14 at 3:43 PM, the resident was observed outside with CNA #3. The resident was smoking a regular cigarette. The CNA was asked the protocol if the resident was smoking an E-cigarette. The CNA stated she had not assisted the resident with an E-cigarette and did not know the protocol. The resident interjected, "The process is no apron."  On 10/28/14 at 4:25 PM, the CNO was asked about use of an apron when the resident smoked an E-cigarette. The CNO stated she wanted staff to use the apron at all times, that way it was not confusing. The CNO was asked if the use of the apron with E-cigarettes was on the care plan. She reviewed the care plan and stated it was not. The CNO agreed that she failed to include it on the E-Cigarette Education Syllabus as well.  On 10/28/14 at 4:45 PM the Administrator and the CNO were informed of the findings. No additional information was provided.	F 280			
{F 323} SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to	{F 323}			

*S. Johnson* CNO 11/20/14

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{F 323}	Continued From page 4 prevent accidents.  This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff and resident interview and review of the facility's Plan of Correction (POC) for the State Agency's survey of 8/21/14 and the Federal Monitoring Survey of 9/25/14, it was determined the facility failed to ensure 2 of 4 sampled residents (#1 & #5), and all ambulatory residents in the facility with cognitive impairments, were free from hazards. Unlocked potentially hazardous liquids placed residents at risk for ingestion and the need for medical intervention. Failure to implement a plan for smoking placed Resident #1 at risk for undetected injury. Findings included:  1. Resident #1 was admitted to the facility with multiple diagnoses to including chronic pain, neurogenic bladder, quadriplegia, c-spine injury, and spasticity.  The surveys of 8/21/14 and 9/25/14 both identified that Resident #1 had sustained cigarette burns as a result of unsafe smoking habits. The POC for the survey of 9/25/14 documented the facility would, "Identify and Monitor resident's skin for burns" with an intervention for "Skin assessment to be completed weekly and with bathing."  The resident's Hygiene Bath/Shower Care record, dated 9/25/14 through 10/28/14, documented 9 opportunities for a skin assessment to be completed with a bath/shower. The record did not	{F 323}	<u>F 323 Issues:</u> 11/20/14 1. Care Plan did not address skin assessment for burns 2. Care Plan and bath schedule did not clearly communicate that Licensed Nurse to do skin assessment on "Full" bath day 3. Room next to chapel without a self locking or locking handle <u>Root Cause:</u> 1 & 2: Plan of Correction regarding completion of skin assessments by License staff was not clearly communicated to licensed staff or documented clearly on the care plan.		

*[Handwritten Signature]* CTO 11/20/14

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{F 323}	<p>Continued From page 5</p> <p>include that a skin assessment for burns had been completed on the documented bath/shower days.</p> <p>The resident's Skin Assessment Flow Sheet dated 9/25/14 through 10/28/14, documented a skin assessment was completed for 10/1, 10/4, 10/7, 10/15, and 10/21 when a partial bed bath had been provided.</p> <p>NOTE: The resident did not have a LN skin assessment from 10/7 to 10/15, which was 8 days.</p> <p>On 10/28/14 at 1:30 PM, LN#2 was asked about the resident's schedule for skin assessments. She stated Resident #1's skin assessments were completed weekly. The "weekly" and "with bathing" parts of the POC were reviewed with her. When asked how staff would know when a skin assessment was to be completed for Resident #1, LN #2 stated they had a sheet that they used identifying when residents were due for a skin assessment. The LN then reviewed the "sheet" and stated the resident was only scheduled for one time per week.</p> <p>On 10/28/14 at 2:07 PM, the CNO was asked if she had provided education to the staff regarding the times when the resident was to have skin assessments. The CNO stated, "No," because it was already on the care plan. The care plan was reviewed.</p> <p>The CNO referred to the resident's care plan, dated 12/28/10 with a focus problem for potential for impaired skin integrity related to spine injury... history of black area of the right heel, history of skin breakdown...bruising and trauma. The focus did not document burns to skin. The care plan</p>	{F 323}	<p>F323: Continue</p> <p>Corrective Action: Resident # 1</p> <ol style="list-style-type: none"> <li>1. Bath schedule updated to include Licensed staff (NOC Shift) to complete skin assessments on bath day in addition to scheduled weekly skin assessment</li> <li>2. Care Plan Problem "Potential for Impaired Skin Integrity" updated to include "Hx of smoke-related burns.</li> <li>3. Care Plan Intervention added to address Skin Assessment on full bath day by licensed in addition to scheduled "weekly" assessment".</li> </ol> <p>System Changes: Refer to F-280 plan of correction regarding care plan updates</p> <p>Quality Monitoring: Skin assessments will be monitored weekly for completion x1 month then monthly.</p> <p>Responsible Party: CNO/designee</p>	
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*S. Johnson* 180 11/20/14

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{F 323}	Continued From page 6 documented interventions for skin assessment weekly, dated 5/31/06, and to monitor skin for redness, blistering, nonblanching or open area and a weekly skin assessment. The interventions did not address burns to skin. The CNO agreed the care plan did not address an assessment of the skin for burns.  2. The facility's POC for the survey of 8/21/14 to protect residents from unlocked hazardous materials, with a compliance date of 9/25/2014, included, "All rooms containing potentially hazardous materials [will be] assessed for self-locking door handles... Self-locking door handles present on all other rooms containing potentially hazardous materials." The POC also stated the facility would perform monthly room checks for hazardous material.  Resident #5 was admitted to the facility on 6/13/13 with diagnoses that included non-Alzheimer's dementia, psychotic disorder, and schizophrenia.  The resident's Quarterly MDS, dated 8/4/14, documented the resident's cognition was moderately impaired and she was able to ambulate independently in her room.  The resident's care plan documented: *Problem: "[Resident's name] has alteration in self-care related to: 1. Dementia... 5. Poor safety awareness." *Interventions: -"Do not keep Efferdent or its equivalent in [resident's name] room. Evening staff to supply one and assist her in its use during HS [hour of sleep] care." Dated 3/24/2013.	{F 323}	#3 Root Cause: Failure to audit clean utility room for potential hazardous items and upon findings, secure the room with locking door.  Corrective Action: Clean utility room secured with locking door 10/28/14.  <u>Identification of other rooms containing potentially hazardous items:</u>  All rooms in the extended care were audited on 10/29/14 for presence of potentially hazardous items included: * clean utility room next to chapel (auto lock applied 10/18/14) * soiled utility room (auto locked applied 10/28/14) * Spa (tub room) locking door present * Personal grooming room (Auto door applied per 09/25/14 POC) *Activity closet in Multi Purpose Room -Locking door present * Activity closet in unit day room present Supply room (auto locking door present)		

*S. Johnson CEO 11/20/14*

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NAME OF PROVIDER OR SUPPLIER  BOUNDARY COUNTY NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 6640 KANIKSU STREET BONNERS FERRY, ID 83805		
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{F 323}	Continued From page 7 On 10/28/14 at 11:40 AM, LN #2 was asked if Resident #5 was still up and walking around. LN #2 said the resident was and that she had been started on a new medication and was doing better with the use of it.  On 10/28/14 at 12:10 PM, the clean utility was observed with the door unlocked. To the left of the sink was an unlocked drawer. In the drawer were 2 boxes of Efferdent tablets, 2 boxes of Effergrip adhesive and 1 tube of Pepsodent toothpaste.  On 10/28/14 at 2:20 PM, LN #2 was asked if there was a monthly room audit for October, as the only audit provided for the resident room checks was 9/17/14. LN #2 stated, "No we just did the one of all the resident rooms. But are continuing to do [resident's name] every day."  On 10/28/14 at 4:25 PM, the CNO was asked why no monthly audit of rooms were done, per the facility's POC. The CNO stated it was done that day. The CNO was asked if it was done after LN #2 was asked about it, and she stated, "Yes, but the month isn't over yet."  3. On 10/28/14 at 9:25 AM, during a tour of the facility, the surveyor observed the Clean Linen Room, next to the chapel, without a self locking or locking handle. In addition to clean linens, this room housed potentially hazardous hygiene and skin care supplies.  The counter top contained 2 - 4 ounce tubes of Calazime skin protectant paste. The ingredients listed on the tubes were zinc oxide, and menthol. The manufacturer's warning on the tube documented, "Keep out of reach of children. If swallowed get medical help or contact a poison	{F 323}	Housekeeping closet(s) Auto locking doors present  <u>Quality Monitoring:</u> All residents rooms audited for potentially hazardous items monthly until 100% compliance.  - All rooms (Starred above) will be checked to ensure doors are closed and locked when not in use  <u>Frequency:</u> Q shift x 1 month <u>Responsible Party:</u> Licensed staff		

*[Handwritten Signature]* 11/20/14

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

PRINTED: 11/13/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135004</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  R <b>10/28/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>BOUNDARY COUNTY NURSING HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>6640 KANIKSU STREET BONNERS FERRY, ID 83805</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{F 323}	<p>Continued From page 8 control center right away."</p> <p>An unlocked cabinet under the sink contained; * 4 - 10 ounce bottles of Barbarsol shaving cream. The ingredients listed were, water, stearic acid, triethanol amine, and isobutane. The bottle documented, "Keep out of reach of children." * 3 - 3 ounce bottles of Afta, Pre-electric Shave. The ingredients listed included alcohol, cassava flour, and stearyl ether. The bottle also documented that it should be kept out of the reach of children and if swallowed, seek medical advice or call the poison control center. * 7 - 8 ounce bottles of No Rinse Body Wash, with listed ingredients of triethalmine and laurel sulfate, and a manufacturers warning to keep out of reach of children.</p> <p>On 10/28/14 at 10:10 AM, the surveyor observed the room with the CNO. The CNO was asked if the Calazime cream belonged on the counter. The CNO stated, "No, it belongs at the nurse's station," and picked them up from the counter. The CNO was asked if the cabinet doors were suppose to be locked, she stated there were locks on them, with no further comment. The CNO removed the Calazime cream from the room.</p> <p>On 10/28/14 at 10:30 AM, and 11:30 AM, the surveyor observed the door to the clean linen room, as well as the under sink cabinet, remained unlocked.</p> <p>On 10/28/14, at 11:40 AM, Staff #1 was interviewed regarding the unlocked cabinets in the clean linen room, that contained potentially hazardous materials, as well as the 2 tubes of Calazime skin protectant that rested on top of the</p>	{F 323}			

*S. J. Liner* cfo 11/20/14

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135004	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  R 10/28/2014
NAME OF PROVIDER OR SUPPLIER  BOUNDARY COUNTY NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 6640 KANIKSU STREET BONNERS FERRY, ID 83805		
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{F 323}	Continued From page 9 counter. Staff #1 stated that the cabinets were generally locked but the facility had received supplies the evening of 10/27, after she went home. Staff #1 stated she was generally the person who received supplies and assured they were properly put away, including locking the undersink cabinet. When asked if any other person was designated to do this in her absence, Staff #1 stated, "No."  On 10/28/2014 at 12:30 pm, the CNO, and the Maintenance director were standing at the door of the clean utility room with a cart of tools and door handles. The CNO stated they were putting a lock handle on the door that staff would need to use a key to open.  On 10/28/2014 at 4:45 PM the Administrator and the CNO were informed that they were not found in compliance with their plan of correction for F323 and the facility would be re-cited. No further information was provided that resolved the concern of residents' safety from potentially hazardous substances.	{F 323}			

*[Handwritten Signature]* 11/20/14

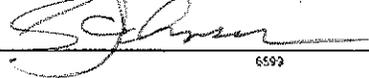
Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  MDS001070	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  R 10/28/2014
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NAME OF PROVIDER OR SUPPLIER  BOUNDARY COUNTY NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 6640 KANIKSU STREET BONNERS FERRY, ID 83805
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{C 000}	16.03.02 INITIAL COMMENTS  The following deficiencies were cited during the follow-up recertification survey of your facility conducted on 10/28/14.  The surveyors conducting the survey were: Susan Gollobit, RN, Team Coordinator and Lorraine Hutton, RN	{C 000}		
{C 342}	02.108,04,b,ii Toxics Stored Under Lock and Key  ii. All toxic chemicals shall be properly labeled and stored under lock and key. This Rule is not met as evidenced by: Please refer to F 323 as it relates to the storage of potentially hazardous substances.	{C 342}	Refer to F323 Plan of Correction	
C 781	02.200,03,a,iii Written Plan, Goals, and Actions  iii. Written to include care to be given, goals to be accomplished, actions necessary to attain the goals and which service is responsible for each element of care; This Rule is not met as evidenced by: Please refer to F280 as it relates to updating care plans.	C 781	Refer to F280 Plan of Correction	
{C 790}	02.200,03,b,vi Protection from Injury/Accidents  vi. Protection from accident or injury; This Rule is not met as evidenced by: Please refer to F 323 as it relates to hazards.	{C 790}	Refer to F323 Plan of Correction	

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



TITLE

CEO

(X6) DATE

11/20/14