



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 5938

December 2, 2014

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

FILE COPY

Provider #: 135064

Dear Ms. Sorensen:

On **November 21, 2014**, a Recertification and State Licensure survey was conducted at Countryside Care & Rehabilitation 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 an isolated deficiency that constitutes actual harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

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

After each deficiency has been answered and dated, the administrator should sign both the Form CMS-2567 and State Form, Statement of Deficiencies and Plan of Correction in the spaces provided and

Bonnie Sorensen, Administrator
December 2, 2014
Page 2 of 4

return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **December 15, 2014**. Failure to submit an acceptable PoC by **December 15, 2014**, may result in the imposition of civil monetary penalties by **January 5, 2015**.

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*.

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 **December 26, 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 **December 26, 2014**.

A change in the seriousness of the deficiencies on **December 26, 2014**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **December**

Bonnie Sorensen, Administrator
December 2, 2014
Page 3 of 4

26, 2014 includes the following:

Denial of payment for new admissions effective **February 21, 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 **May 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, 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 **November 21, 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 an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

<http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/NursingFacilities/tabid/434/Default.aspx>

go to the middle of the page to **Information Letters** section and click on **State** and select the following:

Bonnie Sorensen, Administrator
December 2, 2014
Page 4 of 4

- 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 **December 15, 2014**. If your request for informal dispute resolution is received after **December 15, 2014**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, comments or concerns, please contact Lorene Kayser, L.S.W., Q.I.D.P. or David Scott, R.N., Supervisors, Long Term Care at (208) 334-6626.

Sincerely,

A handwritten signature in black ink that reads "LORENE KAYSER". The letters are in all caps and have a cursive, slightly slanted appearance.

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

LKK/dmj
Enclosures

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 135064	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 11/21/2014
--	--------------------------	--	--

NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE CARE & REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 1224 EIGHTH STREET RUPERT, ID
---	---

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
---------------------	-----------------------------------

F 514	<p>483.75(1)(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 observation, record review and staff interview, it was determined the facility failed to ensure recapitulated Physician's Orders were accurate for wound treatment. This was true for 1 of 9 (#1) sampled residents. Findings included:</p> <p>Resident #1 was admitted to the facility on 6/20/14 with multiple diagnoses which included incomplete quadriplegia.</p> <p>The November 2014 recapitulated Physician's Orders for Resident #1 documented an order for Minnesota Solution topically two times daily to the coccyx for wound care, with a start date of 10/1/14.</p> <p>The November 2014 MAR included the aforementioned Physician's Order with, "dc'd [discontinued]" handwritten under the administration time. No date was provided for the discontinued order.</p> <p>On 11/19/14 at 9:50 a.m., the dressing change to Resident #1's coccyx was observed in the presence of LN #1. The LN used normal saline to cleanse the wound and filled the wound with intrasite gel. When asked if the Minnesota Solution was used, the LN stated, "We haven't been using that for a while."</p> <p>On 11/20/14 at 1:40 p.m., the DON was asked about the process for ensuring recapitulated orders were accurate, and she said recapitulated Physician's Orders were reviewed by the floor nurses before sent out to the physician.</p> <p>On 11/20/14 at 3:25 p.m., the DON said the Minnesota Solution was discontinued on 10/24/14 and, "It should have come off the recaps."</p> <p>On 11/20/14 at 4:15 p.m., the Administrator and DON were informed of the inaccurate recap orders. No further information or documentation was provided.</p>
-------	--

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

The above isolated deficiencies pose no actual harm to the residents

PLAN OF CORRECTION

Deficiency Tag: F – 514 Administration	Problem : Clinical Records not correct Minnesota solution still on recapitulation	Correction Date:
Criteria	Plan of Correction	12/15/14
1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.	Resident #1 was assessed and no adverse reactions resulted from the deficient practice. The Minnesota Solution was discontinued after the physician signed the next month's recapitulation order.	
2. How the facility will identify other residents having the potential to be affected by the same deficient practice.	All residents' recapitulation orders will be reviewed for accuracy.	
3. What measure will be put into place or systemic changes made to ensure that the deficient practice will not occur?	<p>Staff will be inserviced on 12-1-14 and 1-5-15 to attach a copy of the discontinued medication order that was written following the recap orders being sent to the physician for signature.</p> <p>All orders discontinuing a medication following the date the physician signs the recap and the end of the month will be photo copied and attached to the recapitulation form. The clerk will then follow up to make sure it is removed prior to the next recapitulation order generation.</p>	
4. How the facility will monitor its corrective measures to ensure the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the systemic changes.	The DON or her representative will do a weekly QA of recapitulation orders that have had medication changes prior to the end of the month for accuracy until 100% compliance is met for 4 weeks. Then QA monthly until 100 % compliance is met for 3 months. Then quarterly QA's. Findings of the QA checks will be reported to the administrator at the monthly QA committee meetings.	

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

PRINTED: 11/26/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135064	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/21/2014
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE CARE & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 1224 EIGHTH STREET RUPERT, ID 83350		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS The following deficiencies were cited during the annual federal recertification survey of your facility. The surveyors conducting the survey were: Brad Perry, BSW, LSW, Team Coordinator Lauren Hoard RN, BSN The survey team entered the facility on November 17, 2014 and exited on November 21, 2014 Survey Definitions: ADL = Activities of Daily Living BID = Two Time per Day BIMS = Brief Interview for Mental Status CM = Centimeters CNA = Certified Nurse Aide DON = Director of Nursing LN = Licensed Nurse MAR = Medication Administration Record MDS = Minimum Data Set assessment MG = Milligrams PO = By Mouth PRN = As Needed QHS = Every Hour of Sleep TAR = Treatment Administration Record	F 000			
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and	F 314	F-314 1. Resident #1: <ul style="list-style-type: none"> Care plan was revised to include how often incontinence cares should be performed and a specific bowel regimen. Care plan was revised to include more specific direction for placement of coccyx dressing. Care plan was revised to include interventions to ensure skin breakdown did not occur from the catheter tubing. Skin on legs and abdomen coming in contact with the catheter frog was assessed with no blisters or skin irritation found. Continued on page 2 of 26	12/15/14	RECEIVED DEC 15 2014 FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Bonnie Sorenson TITLE Administrator (X6) DATE 12-12-14

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135064	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/21/2014
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE CARE & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 1224 EIGHTH STREET RUPERT, ID 83350		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 314	<p>Continued From page 1</p> <p>services to promote healing, prevent infection and prevent new sores from developing.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident and staff interviews, it was determined the facility failed to ensure residents did not acquire pressure sores for 2 of 3 residents sampled for pressure sores (#1 & #3). Resident #3 was harmed when he acquired a deep tissue injury (DTI) to his right heel when the facility failed to care plan and assess an ankle foot orthosis (AFO) for skin breakdown. He also developed a Stage II pressure sore on his upper left thigh when the facility failed to assess catheter tubing for skin breakdown and then failed to monitor the pressure ulcer after it developed. Resident #1 was harmed when she acquired a Stage II pressure sore on her coccyx which became infected. The resident's bowel incontinence care plan did not direct staff on how often to check for bowel incontinence and during an observation of a dressing change it was determined to be inadequate and could have allowed BM to get into the wound and further infect the site. She also developed a Stage II pressure sore to her right thigh when the facility failed to asses catheter tubing for skin breakdown. Findings include:</p> <p>The facility's High Risk for Pressure Ulcers policy and procedures dated 3/9/09 documented, "Any resident who has a high risk for pressure ulcers will be referred to the wound care nurse for assessment, the wound nurse will make recommendations for interventions."</p>	F 314	<p>F-314 Continued from page 1 of 26</p> <p>Resident #3:</p> <ul style="list-style-type: none"> • Assessed for additional pressure ulcers under his AFO and none were found, • Skin on legs under catheter tubing was assessed with no blisters found. • Care plan was revised to address the use of the AFO • Care plan was revised to address potential skin issues associated with the use of catheters, braces, and AFO's. <p>2. All residents:</p> <ul style="list-style-type: none"> • With a device such as an immobilizer, orthotic or tubing will be checked for pressure areas related to the device. • Who have an immobilizer, orthotic or tubing will have their care plan reviewed for addressing potential skin issues associated with the device. • With pressure ulcers will have their records reviewed for a weekly skin assessment that documents the size, description, color, and resolution. • With pressure ulcers will have their TAR reviewed for documentation (initials) for skin issues monitored with weekly skin checks. <p>3. Staff was inserviced:</p> <ul style="list-style-type: none"> • On 12/1/14, 12/2/14, 1/5/15, and 1/6/15 concerning potential skin issues associated with immobilizers, orthotics, or tubing. • On 12/1/14 and 1/5/15 concerning the proper way to place the coccyx dressing <p>Continued on page 3 of 26</p>		

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

PRINTED: 11/26/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135064	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/21/2014
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE CARE & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 1224 EIGHTH STREET RUPERT, ID 83350		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 314	Continued From page 2 1. Resident #3 was admitted to the facility on 3/9/13 with multiple diagnoses including paralysis agitans, spinal cord disease, and neurogenic bladder. The resident's 7/24/14 significant change MDS, documented the resident was moderately cognitively impaired with a BIMS score of 10, required two person assist with bed mobility and transfers, was totally dependent on two person assist with dressing, had limited range of motion to both lower extremities and, had an indwelling catheter. a. The resident's Physical Therapy Evaluation and Plan of Treatment dated 3/2/13 documented, the resident, "...used an AFO and a hinged knee brace on the right lower extremity. The brace was for the knee...Functional with right ankle immobile with an AFO." The resident's 5/13/14 Mobility care plan, documented interventions of, "Brace to R[ight] leg & knee for ambulation. Remain set at 10-40 degrees" and "Assure hinge of brace is aligned with his knee joint to be effective." The resident's 8/12/14 Skin Integrity care plan, documented interventions of: -"Monitor skin for s/s [signs and symptoms] of infection, breakdown, rashes, hives, skin tears, etc and report to nurse. - Encourage shoe laces not be tight & shoes off when in recliner. - Float heels when in bed. - Skin checks per facility protocol." The care plan did not document the resident used a hard plastic AFO to his right lower leg and foot,	F 314	F-314 continued from page 2 of 26 Policy: <ul style="list-style-type: none"> Was created on 11/24/14 that addresses how to monitor skin when using an immobilizer, orthotic, or tubing. Catheter policy was revised to include alternating the catheter leg strap between legs to avoid skin breakdown. 4. The DON or her representative will do a weekly QA of all skin assessments, pressure ulcers documentation, and care planning until 100% compliance is met for 4 weeks. Then QA monthly until 100% is achieved for 3 months. Then QA quarterly. Findings of the QA checks will be reported to the administrator at the monthly QA committee.		

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

PRINTED: 11/26/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135064	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/21/2014
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE CARE & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 1224 EIGHTH STREET RUPERT, ID 83350		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 314	<p>Continued From page 3</p> <p>when to use the AFO, and how to monitor for skin breakdown where the AFO and brace contacted the resident's body.</p> <p>The resident's Incident/Occurrence Report (I&A), Nursing Flow Sheet Notes (NFSN), Wound Assessment Worksheet (WAW), and Care Plan (CP) documented the following:</p> <p>-10/8/14 I&A, "...P[atient]it was noted to have a purplish/black area to R heel. Wound measures 2.4 x 2.1 cm wound."</p> <p>-10/8/14 NFSN, "CNA states pt had a dr[essin]g to his R heel. Asked pt why it was there. He states it was put there because it was hurting him last night. Upon assessment pt was noted to have a DTI to R heel..."</p> <p>-10/9/14 WAW, Newly Acquired Deep Tissue Injury measured 2.3 by 3.2 cm with 100 percent eschar. "Deep tissue injury just under skin layer."</p> <p>-10/9/14 CP, Interventions, "Betadine to R heel QD [every day]. Brace to R foot off when pt not in w/c [wheel chair] as pt allows. Float heels in recliner & bed...Keep heal [sic] floated. Leg brace off when in recliner. Shoes off when in recliner. Turn and reposition per schedule."</p> <p>The revised care plan still did not include information about the use of the AFO, even after the DTI was discovered.</p> <p>-11/6/14 WAW, DTI measured 2.2 by 2.8 cm with 100 percent eschar. "Remains intact under skin brownish black has not evolved into a scab."</p> <p>-11/14/14 WAW, DTI measured 1.9 by 2.7 cm with 100 percent eschar. "Starting to raise & form a scab."</p> <p>On 11/17/14 at 3:30 PM and at least four other times during the survey, the resident was in his recliner with both heels floated and without a leg brace or AFO attached to his right leg.</p>	F 314			

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

PRINTED: 11/26/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135064	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/21/2014
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE CARE & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 1224 EIGHTH STREET RUPERT, ID 83350		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 314	<p>Continued From page 4</p> <p>On 11/18/14 at 10:00 AM, the resident was interviewed regarding the right heel DTI and he said it was healing fine and did not want a surveyor to look at it.</p> <p>On 11/19/14 at 11:40 AM, the Wound Care Nurse was interviewed regarding the DTI. When asked what caused the DTI, she said the AFO caused the DTI. She said the hard plastic AFO attached with a strap just below the right knee and extended the length of the leg. It curved at the heel and extended to the end of the residents toes. When asked why there was no care plan regarding skin integrity and the use of the AFO and leg brace, she stated, "I don't have it care planned to check for skin." When asked about the importance of skin integrity under a hard AFO or other device, she stated, "We missed looking under the skin."</p> <p>On 11/19/14 at 1:15 PM, CNA #2 was interviewed, while she showed the surveyor the resident's AFO and leg brace. When asked about the use of the leg brace and AFO prior to the skin breakdown, she said the resident only used the hinged leg brace when he walked, but the AFO was used all day long.</p> <p>b. The facility's Catheter Care policy dated 3/3/14, documented, "Be sure catheter is secured to inner thigh with tube holder, and that there are no kinks in catheter...or tubing."</p> <p>The resident's 8/12/14 Bowel and Bladder Supra Pubic Catheter care plan, documented an intervention of, "Care of supra pubic catheter per facility protocol." The care plan did not address potential skin issues associated with the catheter</p>	F 314			

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

PRINTED: 11/26/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135064	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/21/2014
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE CARE & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 1224 EIGHTH STREET RUPERT, ID 83350		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 314	<p>Continued From page 5</p> <p>tubing and if the leg catheter strap was to be alternated between the legs to avoid skin breakdown.</p> <p>The resident's NFSN dated 10/20/14 at 10:00 PM, documented, "Fluid filled blister to L[ef]t [upper] thigh 1 cm x .5 cm. Appears to be caused from cath[eter] tubing. MD faxed."</p> <p>The resident's I&A dated 10/20/14, documented under the Recommendations/Corrective Action section to, "Keep cath tubing from rubbing."</p> <p>The resident's updated 10/20/14 care plan documented under the problem and intervention section, "Fluid filled blister...1. Monitor [with] w[ee]kly skin [check]s. 2. Keep tubing from rubbing. Place gauze on tubing."</p> <p>The resident's 2014 October TAR, weekly skin checks, and NFSN from 10/21/14 to 11/13/14 did not document weekly skin checks were completed for the Stage II pressure ulcer and did not document the size, color, description, or when the ulcer was resolved. The resident's 2014 November TAR documented, "Monitor fluid filled blister to Lt inner thigh with weekly skin checks until resolved." The area of the TAR to document the skin checks were blank.</p> <p>On 11/17/14 at 3:30 PM and throughout the survey, the resident was observed with catheter tubing coming from his left pant leg.</p> <p>On 11/18/14 at 10:00 AM, the resident was interviewed regarding the thigh pressure ulcer and he said it was already healed.</p> <p>On 11/19/14 at 1:40 PM, the DON was</p>	F 314			

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

PRINTED: 11/26/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135064	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/21/2014
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE CARE & REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 1224 EIGHTH STREET RUPERT, ID 83350		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	<p>Continued From page 6</p> <p>interviewed regarding the pressure ulcer. When asked what caused the ulcer, she said it was either from the catheter strap or the tubing itself and said it, "Looks like an area we need to improve." When asked about the lack of direction in the catheter care plan regarding skin breakdown, she said it lacked direction. When asked about the blank November TAR for weekly skin checks, she said, "I noticed that." She said she would follow up with staff.</p> <p>On 11/19/14 at 2:45 PM, the DON reported she checked with the nurse regarding the November skin checks and the nurse told her the ulcer had resolved before November. When asked why there was no documentation about the resolved ulcer, she said, "We missed it." When asked why the weekly skin check intervention was not added to the October 2014 TAR, she said, "We will do better."</p> <p>2. Resident #1 was admitted to the facility on 6/20/14 with multiple diagnoses which included spinal chord injury with incomplete quadriplegia and neurogenic bladder.</p> <p>Resident #1's admission MDS assessment, dated 6/26/14, documented the resident was cognitively intact with a BIMS of 15, required total assistance for bed mobility, transfers, toilet use and bathing, required extensive assistance for dressing and personal hygiene, had range of motion impairments to bilateral upper and lower extremities, was always incontinent of bowel, had an indwelling catheter and had no pressure ulcers.</p> <p>The most recent quarterly MDS assessment, dated 9/16/14, documented Resident #1 had a</p>	F 314		

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

PRINTED: 11/26/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135064	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/21/2014
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE CARE & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 1224 EIGHTH STREET RUPERT, ID 83350		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 314	<p>Continued From page 7 Stage 3 pressure ulcer.</p> <p>Resident #1's Skin Integrity Care Plan, dated 7/3/14, documented a risk for alteration in skin integrity. The interventions included to keep skin clean and dry, total assist of 2 for bed mobility, air mattress on the bed, egg crate and sheep skin to electric wheelchair, apply special lotions/creams to maintain skin integrity, barrier cream to moisture exposed skin, skin checks per facility protocol, monitoring skin for signs and symptoms of infection and breakdown, "She prefers not to be put on a schedule r/t [related to] the air bed is set up to turn her Q [every] 1 hour and she prefers staff not to disturb her when she is in bed," and, " Declined roho [a special cushion for a chair] use 7/7/14."</p> <p>Resident #1's Bowel and Bladder/Supra Pubic Care Plan, dated 7/3/14, documented a risk for alteration in elimination. Interventions included incontinence cares as needed, total assist of 2 for incontinence cares, bowel regimen per MD and per facility protocol, calmoseptine as ordered to buttocks, suppository as ordered, care of supra pubic foley catheter per facility protocol and physician orders and wears incontinence briefs.</p> <p>The Bowel and Bladder Care Plan did not document how often incontinence cares should be performed.</p> <p>a. An Incident/Occurrence Report for Resident #1, dated 8/13/14, documented an open area to coccyx which measured 3 cm x 1.4 cm.</p> <p>The following documentation was gathered from Resident #1's Physical Therapy Evaluation and Plan of Treatment and Physical Therapy Progress</p>	F 314			

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

PRINTED: 11/26/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135064	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/21/2014
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE CARE & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 1224 EIGHTH STREET RUPERT, ID 83350		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 314	Continued From page 8 Notes (PT), Wound Nurse Consultation (WNC), Wound Assessment Worksheet (WAW), Physician's Orders (PO) and Nursing Flow Sheet (NFS): 8/14/14 (WNC) - "[Resident's name] has developed an open superficial area to her mid coccyx. Measures 2.3 cm x 1.6 cm x 0.0 cm. Top half of wound is white macerated skin from ruptured blister and is still attached to healthy peri wound. Bottom half of wound is pink, moist, and superficial. Roho cushion was offered to her when she was first admitted and she declined to have one. She now agrees to roho use and has had an air mattress on her bed for years. She also declined a turning and repositioning schedule in bed as she wanted her airbed to turn her. She stated her and her care givers have done this for years with no problems. She has now agreed to be turned and repositioned Q [every] 2 hours and PRN except when she is sleeping. She has been encouraged to be down between meals as she is able. She does have a history of a pressure ulceration to her bottom in the past. She has been explained the risk of declining roho and turning and repositioning. Good nutrition habits have also been explained to her..." 8/14/14 (PO) - Optifoam dressing to coccyx wound every 3 days and prn until healed; Measure coccyx wound every week and document on wound sheet; Assess wound for dressing, odor, drainage signs and symptoms of infection and pain. document changes in nursing notes; 8/28/14 (PT) - "Anticipated Goals: 1. Patient to show wound healing with no increase in signs or symptoms of infection to the coccyx area;" 9/3/14 (PT) - "...Patient received sharps debridement to the coccyx area with feces initially	F 314			

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

PRINTED: 11/26/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135064	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/21/2014
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE CARE & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 1224 EIGHTH STREET RUPERT, ID 83350		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 314	Continued From page 9 being cleaned up...;" 9/10/14 (PT) - "...prepped for debridement by cleaning feces out of the area...;" 9/14/14 (WAW) - Odor present; 9/24/14 (PT) - "A slight odor was noted and dressing was removed and patient reports that the dressing was just changed last night secondary to feces on the dressing...Wound has a slight odor...;" 10/1/14 (PT) - "...cleaned prior to debridement as she has had a bowel movement...No appreciable wound odor is noted however this could be masked from the odor of the feces...also requesting an order to culture the wound as the patient has had some MRSA[Methicillin-resistant Staphylococcus aureus] in the past...;" 10/1/14 (PO) - Minnesota Solution 1 application topically two times daily to coccyx for wound care; Wound culture; 10/6/14 (NFS) - [MD's name] called. States pt [patient] needs abx [antibiotics] for wound N.O. [New Order] Cipro 500 mg [one tablet] PO BID x 1 wk [week];" 10/6/14 (PO) - Cipro 500 mg one tablet PO BID times 1 week for wound infection; 10/8/14 (PT) - "RN reports that the patient is taking Cipro, since Monday, and the cultures did not indicate MRSA...No significant odor was detected with wound debridement today...;" 10/9/14 (NFS) - "Res[ident] continues on abx for coccyx wound infection..." (similar nurse's notes on 10/9, 10/10, 10/11, 10/12 and 10/13/14.); 10/15/14 (PT) - "...is no longer taking an antibiotic...;" 10/22/14 (PT) - "...It is likely that a wound vac will keep the wound cleaner as feces continue to contaminate the wound on a near daily basis...;" 10/22/14 (PO) - Wound vac to coccyx change 3 times per week;	F 314			

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

PRINTED: 11/26/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135064	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/21/2014
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE CARE & REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 1224 EIGHTH STREET RUPERT, ID 83350	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
F 314	<p>Continued From page 10</p> <p>10/25/14 (NFS) - "Wound vac placed to coccyx...;"</p> <p>11/1/14 (WAW) - Odor present;</p> <p>11/5/14 (PT) - "...necrosis in the wound with an odor...;"</p> <p>11/5/14 (WAW) - Odor present;</p> <p>11/7/14 (PO) - Wound culture;</p> <p>11/7/14 (PT) - "...no odor detected...;"</p> <p>11/8/14 (NFS) - "[MD's name] returned his phone call from yesterday. N.O...wound culture...While [changing] pts drsg to coccyx, a foul odor was noted. Odor was not noted yesterday...;"</p> <p>11/12/14 (NFS) - "...Res[ident] started on abx tx [treatment] r/t [related to] wound culture...;"</p> <p>11/15/14 (NFS) - "...She is on abx for wound...;" and,</p> <p>11/20/14 (PT) - "...No odor was detected with the wound dressing was removed...."</p> <p>On 11/19/14 at 9:50 a.m., the dressing change to the coccyx was observed with LN #1 and CNA #2 present. After the LN cleansed the pressure ulcer and applied intrasite gel, an optifoam dressing was placed over the wound. The dressing was not tucked into the gluteal crease to prevent contamination of feces; there was a direct tunnel from the anus to the wound.</p> <p>On 11/19/14 at 11:11 a.m., LN #5 clarified the typed date on the care plan correlated with the typed interventions. The LN said Resident #1 had a bowel regimen in the evening which was to have a bowel movement during the night and was then cleaned up.</p> <p>On 11/20/14 at 1:40 p.m., the DON was asked how often incontinence care was to be performed for Resident #1, and she stated, "As needed." The resident had a supra pubic catheter and had</p>	F 314	
			(X5) COMPLETION DATE

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

PRINTED: 11/26/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135064	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/21/2014
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE CARE & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 1224 EIGHTH STREET RUPERT, ID 83350		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 314	<p>Continued From page 11</p> <p>a bowel routine with smearing during the day. When asked what the care plan said about the concern, the DON stated, "Nothing very specific."</p> <p>Resident #1 developed a Stage 2 pressure ulcer the day before risks and benefits of the resident's choices to decline skin preventative measures were explained. The resident's care plan did not provide instruction on how often to perform incontinence cares for bowel movements, nor did it describe the bowel regimen. A dressing change was observed and showed how easily feces could get into the coccyx wound. The resident was harmed when the pressure ulcer became infected.</p> <p>b. An Incident/Occurrence Report for Resident #1, dated 9/3/14, documented a closed blister to the resident's right upper, inner thigh approximately 0.5 cm in length. The resident thought it was caused by the catheter frog [tubing] when she was seated. The corrective action included repositioning the frog so it did not rest under the resident's abdominal fold.</p> <p>A Nursing Flow sheet, dated 9/3/14, documented, "When [changing] res[ident] for bed found closed [0.5] cm blister to [the right upper] inner thigh. Res [states] she thinks it was caused by catheter frog when sitting."</p> <p>Resident #1's Care Plan was updated on 9/3/14 with the problem documented as a blister to the right upper inner thigh, would resolve without signs and symptoms, and the intervention was to monitor and position the frog so it did not touch in the abdominal fold.</p> <p>Resident #1's Care Plan did not include</p>	F 314			

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

PRINTED: 11/26/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135064	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/21/2014
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE CARE & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 1224 EIGHTH STREET RUPERT, ID 83350		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 314	Continued From page 12 interventions to ensure skin breakdown did not occur from the catheter tubing. A Physical Therapy Progress Note for Resident #1, dated 9/3/14, documented, "...A discussion is also made, during today's visit, regarding blistering which are occurring from the catheter along the patient's upper thigh and abdominal region. Some strategies were discussed to alleviate this blistering and calmoseptine was applied by the CNA..." There was no documentation in Nurses's Notes, Physician's Orders or the Care Plan as to what the strategies were to alleviate blistering. In addition, the blister was not assessed or tracked after the initial assessment on 9/3/14. On 11/19/14 at 11:10 a.m., LN #5 was asked about the blister to Resident #1's right inner thigh and she said she was not involved with the blister. On 11/19/14 at 1:40 p.m., the DON said she thought Resident #1's blister was from the catheter tubing or frog and that the frog was supposed to help with pressure. When asked if the blister had resolved, the DON said, "Yes," and was unsure of when. On 11/19/14 at 5:25 p.m., the Administrator and DON were informed of the concerns with the development of a pressure ulcer which became infected, and of the pressure ulcer caused by catheter tubing. No further information or documentation was provided.	F 314			
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS	F 328			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135064	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/21/2014
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE CARE & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 1224 EIGHTH STREET RUPERT, ID 83350	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 328	Continued From page 13 The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure oxygen was turned on for a resident receiving oxygen therapy, and to include as needed oxygen orders on the MAR or TAR. This was true for 2 of 6 (#s 4 & 5) sampled residents. This created the potential for an increase in respiratory problems if the residents' respiratory needs were not met. Findings included: 1. Resident #4 was admitted to the facility on 5/18/13 with multiple diagnoses which included mild dementia and hypoxia. The most recent quarterly MDS assessment, dated 9/25/14, documented Resident #4 had impaired cognition with a BIMS of 5. Resident #4's Oxygen Care Plan, dated 4/28/14, documented an alteration in respiratory status related to weakness and hypoxia with an intervention for continuous oxygen as ordered via nasal cannula.	F 328	F-328 1. Resident #4: <ul style="list-style-type: none"> Was assessed and was found not to be affected by the deficient practice. O2 monitoring and orders were moved from the "O2 binder" to the TAR. Resident #5: <ul style="list-style-type: none"> Was assess and was found not to be affected by the deficient practice. Was assessed and was found that she no longer needed O2. O2 was discontinued. 2. All residents who have an order for O2: <ul style="list-style-type: none"> Will be assessed for their availability of oxygen. Will have their O2 orders and monitoring moved from the "O2 binder" to the TAR. 3. Staff was inserviced on 12/1/14, 12/2/14, 1/5/15, and 1/6/15 <ul style="list-style-type: none"> For the CNA to notify the nurse that the O2 canister needs to be turned on when the resident is placed on a portable oxygen container. That the O2 monitoring would now be place on the TAR. 4. The DON or her representative will do a weekly QA of all portable oxygen containers and residents with O2 having their O2 monitoring placed on the TAR, this will continue until 100% compliance is met for 4 weeks, then monthly until 100% compliance is met for 3 months, then quarterly. Findings of the QA checks will be reported to the administrator monthly at the QA committee meetings.	12/15/14

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

PRINTED: 11/26/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135064	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/21/2014
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE CARE & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 1224 EIGHTH STREET RUPERT, ID 83350		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 328	Continued From page 14 The November 2014 recapitulated Physician's Orders for Resident #4 documented an order for oxygen at 2 liters per minute per nasal cannula continuous. On 11/18/14 at 12:09 p.m., Resident #4 was observed in the dining room for the lunch meal. A portable oxygen tank was hanging on the back of the wheelchair, the nasal cannula was in place and the dial was turned to zero. At 12:20 p.m., LN #1 was asked how much oxygen Resident #4 was to receive and she said 2 liters continuous. The LN accompanied the surveyor into the dining room to observe the amount of oxygen the resident was receiving. The LN stated the oxygen was, "On zero" and turned the tank on to 2 liters per minute. On 11/19/14 at 5:25 p.m., the Administrator and DON were informed of the observation with oxygen not turned for Resident #4. No further information or documentation was provided. 2. Resident #5 was admitted to the facility on 6/21/13 with multiple diagnoses including hypertension. The resident's October and November 2014 recapitulation orders documented an order dated 1/28/14, "Oxygen at 2 liters per minute per nasal cannula PRN...If oxygen saturation level falls below 88% staff may increase oxygen..." The resident's 9/29/14 Oxygen care plan, documented an intervention of, "Oxygen as ordered PRN." The resident's October and November 2014 TAR	F 328			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135064	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/21/2014
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE CARE & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 1224 EIGHTH STREET RUPERT, ID 83350		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 328	Continued From page 15 included to check and change oxygen tubing and concentrator, but did not include the order for oxygen therapy and the parameters. The resident's October and November 2014 Oxygen Monitor Form, documented, the resident's daily saturation levels were above 88% on room air. On 11/17/14 at 3:25 PM and throughout the survey, the resident's room did not contain an oxygen tank or concentrator. On 11/19/14 at 1:30 PM, LPN #5 was interviewed. When shown the October and November 2014 TAR, she acknowledged the order and the parameters were missing from the form. On 11/20/14 at 4:15 PM, the Administrator and DON were informed of the oxygen issues. No further information was provided by the facility.	F 328			
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	F 329	F-329 Resident #1: it was determined from the physician progress note that the Cipro was to treat a urinary tract infection. Resident #4, and Resident #9: <ul style="list-style-type: none"> An assessment will be done to determine the underlying cause of the anxiety. Care plan revised to describe signs and symptoms of anxiety Care plan revised to provide instruction to monitor for signs and symptoms of anxiety Care plan revised to provide instruction on how to manage anxiety should it occur Care plan revised to provide non-pharmacological interventions to use prior to administration of anti-anxiety medication. Continued on page 17 of 26	12/15/14	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135064	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/21/2014
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE CARE & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 1224 EIGHTH STREET RUPERT, ID 83350	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	<p>Continued From page 16</p> <p>therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure assessments were made to determine the cause of anxiety before administration of anti-anxiety medication, had specific indications for use of anti-anxiety medication and antibiotics, had adequate monitoring for signs and symptoms (s/sx) of anxiety and adverse side effects, and had direction in the care plan for monitoring and managing symptoms of anxiety. This was true for 3 of 5 (#s 1, 4 & 9) sampled residents reviewed for anti-anxiety medications. This failure had the potential for harm if residents received drugs not needed to treat a specific medical condition, or experienced adverse side effects of those drugs. Findings included:</p> <p>1. Resident #4 was admitted to the facility on 5/18/13 with multiple diagnoses which included mild dementia and depression.</p> <p>The most recent quarterly MDS assessment, dated 9/25/14, documented Resident #4 had impaired cognition with a BIMS of 5 and had not received anti-anxiety medication.</p>	F 329	<p>F-329 continued from page 16 of 26</p> <p>2. All residents who are taking medications will have their medical record reviewed for corresponding diagnoses</p> <p>All residents who are taking an as needed anti-anxiety medication will have:</p> <ul style="list-style-type: none"> • An assessment done to determine the underlying cause of the anxiety • Care plan revised to describe signs and symptoms of anxiety • Care plan revised to provide instruction to monitor for signs and symptoms of anxiety • Care plan revised to provide instruction on how to manage anxiety should it occur • Care plan revised to provide non-pharmacological interventions to use prior to administration of anti-anxiety medication <p>3. Staff was inserviced on 12/1/14 and 1/5/15 concerning:</p> <ul style="list-style-type: none"> • Appropriate charting on the behavior monitoring sheets • Appropriate care planning of signs and symptoms • Management of anxiety • No-pharmacological interventions to be used prior to administration of anti-anxiety medication • Getting a diagnosis for a medication and placing it on the physicians order prior to administration of the medication. <p>Continued on page 18 of 26</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135064	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/21/2014
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE CARE & REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 1224 EIGHTH STREET RUPERT, ID 83350		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	<p>Continued From page 17</p> <p>Resident #4's Care Plan documented the problem of increased anxiety, a goal to resolve the anxiety, and one intervention to administer antianxiety as ordered, with a date of 7/9/14.</p> <p>The Care Plan did not describe s/sx of anxiety for Resident #4, did not provide instruction to monitor for s/sx of anxiety, how to manage anxiety should it occur, or non-pharmacological interventions to use prior to administration of the antianxiety medication.</p> <p>The November 2014 recapitulated Physician's Orders for Resident #4 documented an order for Xanax 0.25 MG by mouth every 8 hours as needed for anxiety, with a start date of 7/9/14.</p> <p>The November 2014 MAR documented Resident #4 received Xanax 10 times. The reasons documented for administration of the medication included yelling out every minute, yelling out and increased anxiety. On 5 occasions, the antianxiety medication was administered in conjunction with pain medication, "c/o [complaints of] pain [and] yelling out."</p> <p>The November 2014 Psychotropic Drug Use/Behavior Problem Supporting Documentation form documented zero occurrences of anxiety for Resident #4.</p> <p>On 11/19/14 at 3:20 p.m., the DON was interviewed and she said Resident #4 would receive Xanax if she had behaviors, and would sometimes call out to her deceased husband. The indications were, "Not very specific," and non-pharmacological interventions would include trying to reassure and calm the resident. When</p>	F 329	<p>F-329 continued from page 17 of 26</p> <p>The Psychoactive Medication policy was revised to include determining underlying cause of behavioral symptoms, to describe the signs and symptoms, how to manage them and how to provide non-pharmacological interventions.</p> <p>4. The DON or her representative will do a weekly QA of resident's medications and corresponding diagnosis, residents with antianxiety medication care plans and behavior documentation until 100% compliance is met for 4 weeks. The QA monthly until 100% compliance is met for 3 months. Then quarterly QA's. Findings of the QA checks will be reported to the administrator at the monthly QA committee meetings.</p>	

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

PRINTED: 11/26/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135064	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/21/2014
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE CARE & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 1224 EIGHTH STREET RUPERT, ID 83350		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 329	<p>Continued From page 18</p> <p>asked what the care plan said about non-pharmacological interventions for the resident, the DON stated, "I'm not sure it says anything further," and after reading the care plan she stated, "Nope, that's as far as we went." The DON was asked if an assessment was done to determine the underlying cause of Resident #4's anxiety and she said, "I'm not aware there was an assessment for the underlying cause." The DON said the nurses monitored for adverse side effects but were, "probably not" documented anywhere.</p> <p>On 11/20/14 at 4:15 p.m., the Administrator and DON were informed of the concerns related to as needed antianxiety medication. No further information or documentation was provided.</p> <p>2. Resident #1 was admitted to the facility on 6/20/14 with multiple diagnoses which included spinal chord injury with incomplete quadriplegia.</p> <p>A handwritten Physician's Order for Resident #1, dated 11/14/14, documented, "Cipro 500 mg [one tablet] PO BID x 7 days." The order did not contain an indication for the use of the antibiotic.</p> <p>Resident #1's November 2014 MAR documented the aforementioned Physician's Order. The MAR did not contain an indication for the use of the antibiotic.</p> <p>On 11/20/14 at 1:40 p.m., the DON was asked what the antibiotic was for and she said she was not sure, but a guess would be for Resident #1's wound. The resident also had a urinary tract infection and the antibiotic could have been for that.</p>	F 329			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135064	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/21/2014
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE CARE & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 1224 EIGHTH STREET RUPERT, ID 83350		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 329	<p>Continued From page 19</p> <p>On 11/20/14 at 4:15 p.m., the Administrator and DON were informed of the lack of indication for use of an antibiotic. No further information or documentation was provided.</p> <p>3. Resident #9 was admitted to the facility on 3/8/13 with multiple diagnoses including congestive heart failure and partial blindness.</p> <p>The resident's 8/5/14 quarterly MDS assessment, documented the resident was cognitively intact with a BIMS of 12 and had not received antianxiety medication.</p> <p>The resident's Depression/Anxiety care plan, dated 8/12/14, did not document a problem related to anxiety and documented only one intervention related to anxiety which was to administer antianxiety as ordered. The care plan did not describe signs and symptoms of anxiety for the resident, how to manage anxiety should it occur, and did not include non-pharmacological interventions to use prior to administration of the antianxiety medication.</p> <p>The resident's Social Service Progress Note dated 8/12/14, documented: "On 8/11/14 as this worker was leaving for the evening, [Resident's Name] was sitting by the front door in a chair...[Resident's Name] stated that she wished that she could go home. She stated that she was very depressed. She stated that she wished her doctor would give her something."</p> <p>The resident's Nursing Flow Sheets dated 8/12/14 at 9:00 AM, documented, "Resident stated that she wanted me to contact Dr.</p>	F 329			

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

PRINTED: 11/26/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135064	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/21/2014
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE CARE & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 1224 EIGHTH STREET RUPERT, ID 83350		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 329	<p>Continued From page 20 [Physician's Name] to get her something for depression & anxiety."</p> <p>The resident's Physician's progress note dated 8/12/14 at 10:30 AM, documented, "P[atien]t very anxious and depressed today...I wasn't aware of her being depressed but she says, "for a while."</p> <p>The resident's Physician's order dated 8/12/14, documented, "Alprazolam 0.25 mg BID PRN anxiety DC [discontinue] after 2 months if not used."</p> <p>The resident's Psychotropic Drug Use/Behavior Problem Supporting Documentation (Behavior Monitor) under the anxious mood column from 8/1 to 8/12/14 and from 8/14 to 11/19/14 documented zeros for each shift under the heading, where zero equaled behavior was not exhibited.</p> <p>The resident's August 2014 MAR documented the resident received the medication 14 times. The reasons documented for administration of the medication included, increased anxiety, one time for, "I just don't know what to do", and another time, "I want to get some sleep."</p> <p>The resident's Physician's progress note dated 9/2/15 at 11:15 AM, documented, "...Alprazolam helps her anxiety and sleep. Will make it 0.25 QHS."</p> <p>The resident's MARs from 9/2 through 11/19/14, documented the resident received the antianxiety medication every night.</p> <p>On 11/20/14 at 1:15 PM, the Social Worker was interviewed regarding the antianxiety medication.</p>	F 329			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135064	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/21/2014
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE CARE & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 1224 EIGHTH STREET RUPERT, ID 83350		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 329	Continued From page 21 When asked if the care plan had non-pharmalogical approaches or other interventions to address anxiety, she said, it was not on the care plan. She was shown the behavior monitors and was asked what anxious mood for the resident looked like so staff would know what to look for, she said the behavior was attention seeking, but said it was not documented on the form. When asked why the resident received the PRN medication in August, even though the behavior monitors showed the resident did not exhibit anxiety, she said, "I see what you are saying."	F 329			
F 371 SS=F	On 11/20/14 at 4:15 PM, the Administrator and DON were informed of the medication issues. No further information was provided by the facility. 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: Based on observation and staff interview, it was determined the facility failed to ensure kitchen and facility staff wore hair nets when in the kitchen and mugs were free from debris and gouges. This was true for 9 of 9 (#s 1-9) sampled	F 371	F-371 1. Deficient practices have been corrected by implementing the following standard operating procedures: <ul style="list-style-type: none"> All managers, dietary staff, hospital and long term care facility staff, and vendors entering the kitchen will be required a hair restraint (hairnet, hat, or bonnet) while in the kitchen. Hair restraints will be readily available at all kitchen entrances. Although there was a potential for a deficient practice(s) to cause harm, no evidence of harm was found. 2. Lack of properly sanitized dishware or lack of using a hairnet in food prep areas could potentially affect 100% of residents. 3. The RD and CDM will in-service dietary staff and non-staff of standard operating procedures for hair restrain use and dish handling and washing procedures. 4. The facility RD will conduct monthly audits of sanitation for cleanliness/condition of dishware and hair restraint use to ensure proper practices are in place. Audit results will be reported to the Quality Assurance monthly.	12/15/14	

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

PRINTED: 11/26/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135064	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/21/2014
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE CARE & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 1224 EIGHTH STREET RUPERT, ID 83350		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 371	<p>Continued From page 22</p> <p>residents and any resident who ate food prepared in the facility's kitchen. This practice created the potential for contamination of food and exposed residents to potential sources of disease causing pathogens. Findings include:</p> <p>On 11/17/14 at 12:50 p.m., during the initial tour of the kitchen with the Dietary Manager (DM) in attendance, the DM was observed without a hair net in place. The DM said he never wears one in the kitchen unless he is preparing food, in which he wears a hat, and contracting personnel did not wear a hair net when carting supplies on a path through the kitchen.</p> <p>On 11/18/14 at 9:25 a.m., the DM was observed in the kitchen without a hair net in place. In addition, 2 out of 10 mugs were observed to have scratches and gouges on the inside surface, as well as a gray, dusty debris which could easily be wiped away. The DM said when mugs are found with scratches and gouges they are tossed out and replaced immediately.</p> <p>On 11/18/14 at 11:45 a.m., during observation of tray line and temperatures, with the DM present, a Human Resources staff member #3 was observed to walk into the kitchen, pass 2 preparation tables and back out of the kitchen without a hair net in place. The DM stated, "See, that's what happens."</p> <p>The 2009 FDA Food Code, Chapter 2, Part 2-4, Hygiene Practices, Hair Restraints, subpart 402.11, Effectiveness, indicates, "(A) Except as provided in ¶ (B) of this section, food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn</p>	F 371			

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

PRINTED: 11/26/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135064	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/21/2014
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE CARE & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 1224 EIGHTH STREET RUPERT, ID 83350		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 371	Continued From page 23 to effectively keep their hair from contacting exposed food; clean equipment, utensils, and linens; and unwrapped single-service and single-use articles. (B) This section does not apply to food employees such as counter staff who only serve beverages and wrapped or packaged foods, hostesses, and wait staff if they present a minimal risk of contaminating exposed food...chapter 4 Equipment, Utensils, and Linens, Subpart 4-202 Cleanability documented, "4-202.11 Food-Contact Surfaces. (A) Multiuse food-contact surfaces shall be: (1) Smooth; (2) Free of breaks, open seams, cracks, chips, inclusions, pits, and similar imperfections..."	F 371			
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.	F 441	F-441 Resident #1: Resident was assessed and no adverse reactions were found. All residents who receive incontinent cares are at risk or may be affected by the same deficient practice. The CNA was inserviced concerning the proper technique to handle dirty linens and hand washing protocol. Staff inserviced on 12/1/14, 12/2/14, 1/5/15, and 1/6/15 concerning the proper way to handle dirty linens, chucks, and pads and the appropriate hand washing and glove use techniques. The DON or her representative will do a weekly QA of hand washing and the handling of dirty linens, chucks, and pads until 100% compliance is met for 4 weeks. The QA monthly until 100% compliance is met for 3 months. Then quarterly QA's. Findings of the QA checks will be reported to the administrator at the monthly QA committee meetings.	12/15/14	

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

PRINTED: 11/26/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135064	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/21/2014
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE CARE & REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 1224 EIGHTH STREET RUPERT, ID 83350		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	<p>Continued From page 24</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure hand hygiene was performed after incontinence care. This was true for 1 of 6 (#1) sampled residents. This deficient practice placed residents at risk for infections due to transmission of microorganisms. Findings included:</p> <p>Resident #1 was admitted to the facility on 6/20/14 with multiple diagnoses which included spinal chord injury with incomplete quadriplegia.</p> <p>On 11/19/14 at 9:50 a.m., a dressing change to Resident #1's coccyx was observed by the surveyor, during which bowel incontinence care was performed by LN #1 and CNA #2. The CNA</p>	F 441		

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

PRINTED: 11/26/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135064	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/21/2014
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE CARE & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 1224 EIGHTH STREET RUPERT, ID 83350		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	<p>Continued From page 25</p> <p>removed the soiled incontinence pads and placed them into the trash. Without removing the gloves and performing hand hygiene, the CNA proceeded to touch pillows, clean incontinence pads, the indwelling catheter bag, a draw sheet, blankets and the resident's legs while assisting to reposition the resident. The CNA removed the gloves and touched the blinds and call light, and donned a new pair of gloves without performing hand hygiene. After the CNA removed the gloves, hand hygiene was performed prior to leaving the resident's room.</p> <p>On 11/19/14 at 10:10 a.m., CNA #2 was interviewed about the lack of hand hygiene and she said, "I should have changed my gloves."</p> <p>On 11/20/14 at 4:15 p.m., the Administrator and DON were informed of the hand washing issue. No further information or documentation was provided.</p>	F 441			

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001490	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/21/2014
--	---	---	--

NAME OF PROVIDER OR SUPPLIER: COUNTRYSIDE CARE & REHABILITATION
STREET ADDRESS, CITY, STATE, ZIP CODE: 1224 EIGHTH STREET RUPERT, ID 83350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	16.03.02 INITIAL COMMENTS The following deficiencies were cited during the State licensure survey of your facility. The surveyors conducting the survey were: Brad Perry, BSW, LSW, Team Coordinator Lauren Hoard RN, BSN	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 relates to sanitary conditions in the kitchen.	C 325	C 325 Refer to F-371	12/15/14
C 492	02.121,05,d,ix Meet Window Requirments ix. Each room shall have a window which can be opened without the use of tools. The window sill must not be higher than three (3) feet above the floor and shall be above grade. The window shall be at least one- eighth (1/8) of the floor area and shall be provided with shades or drapes; This Rule is not met as evidenced by: Based on staff interview, it was determined the facility failed to ensure resident rooms on the West hall had windows which opened. This affected 5 of 9 (#s 1, 3, 4, 6 & 7) sampled residents and all other residents who resided on the West hall, 1 of 3 resident halls. Findings	C 492	C 492 Please renew windows waiver for resident room numbers 301-317.	12/15/14

RECEIVED
DEC 15 2014
FACILITY STANDARDS

Bureau of Facility Standards
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Bonnie Sorenson TITLE: Administrator (X6) DATE: 12-12-14
STATE FORM 6899 YNFZ11 If continuation sheet 1 of 4

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001490	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/21/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE CARE & REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 1224 EIGHTH STREET RUPERT, ID 83350
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 492	Continued From page 1 included: On 11/17/14 at 3:20 PM, the Administrator confirmed the windows in rooms 301 through 317 were non-operable and could not be opened. The Administrator stated the facility would continue to request a waiver of the requirement.	C 492		
C 669	02.150,03 Resident Protection 03. Patient/Resident Protection. There is evidence of infection control, prevention and surveillance in the outcome of care for all patients/residents as demonstrated by: This Rule is not met as evidenced by: Refer to F441 as it relates to infection prevention.	C 669	C 669 Refer to F441	12/15/14
C 788	02.200,03,b,iv Medications, Diet, Treatments as Ordered iv. Delivery of medications, diet and treatments as ordered by the attending physician, dentist or nurse practitioner; This Rule is not met as evidenced by: Refer to F328 as it relates to following physician orders for oxygen therapy.	C 788	C 788 Refer to F328	12/15/14
C 789	02.200,03,b,v Prevention of Decubitus v. Prevention of decubitus ulcers or deformities or treatment thereof, if needed, including, but not limited to, changing position every two (2) hours when confined to bed or wheelchair and opportunity for	C 789	C 789 Refer to F 314	12/15/14

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001490	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/21/2014
--	---	---	--

NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE CARE & REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 1224 EIGHTH STREET RUPERT, ID 83350
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 789	Continued From page 2 exercise to promote circulation; This Rule is not met as evidenced by: Refer to F314 regarding development of pressure ulcers and pressure ulcer care.	C 789	C 798 Refer to F 329	12/15/14
C 798	02.200,04,a Medication Administration - Written Orders 04. Medication Administration. Medications shall be provided to patients/residents by licensed nursing staff in accordance with established written procedures which shall include at least the following: a. Administered in accordance with physician's dentist's or nurse practitioner's written orders; This Rule is not met as evidenced by: Refer to F329 as it relates to indications of use for antianxiety and antibiotic medications.	C 798		
C 803	02.200,04,f Observed for Reactions f. Patients/residents are observed for reactions to medications and if a reaction occurs, it is immediately reported to the charge nurse and attending physician; This Rule is not met as evidenced by: Refer to F329 as it relates to monitoring for adverse side effects of PRN antianxiety medication.	C 803	C 803 Refer to F329	12/15/14
C 881	02.203,02 Individual Medical Record 02. Individual Medical Record. An individual medical record shall be maintained for each admission with all	C 881	C 881 Refer to F514	12/15/14

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001490	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/21/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE CARE & REHABILITATION	1224 EIGHTH STREET RUPERT, ID 83350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 881	Continued From page 3 entries kept current, dated and signed. All records shall be either typewritten or recorded legibly in ink, and shall contain the following: This Rule is not met as evidenced by: Refer to F514 as it relates to accurate records.	C 881		