



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 1010 0002 0836 1994

December 17, 2013

John L. Hoopes, Administrator
Caribou Memorial Living Center
300 South Third West
Soda Springs, ID 83276-1559

Provider #: 135060

Dear Mr. Hoopes:

On **December 6, 2013**, a Recertification and State Licensure survey was conducted at Caribou Memorial Living Center by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be 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.) Please provide ONLY ONE completion date for each federal and state tag in column X5 Complete 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

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CMS-2567 and State Form in the spaces provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **December 30, 2013**. Failure to submit an acceptable PoC by **December 30, 2013**, may result in the imposition of civil monetary penalties by **January 20, 2014**.

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

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. This monitoring will be reviewed at the follow-up survey, as part of the process to verify that the facility has corrected the deficient practice. Monitoring must be documented and retained for the follow-up survey. In your Plan of Correction, please be sure to include:
 - a. Specify by job title who will do the monitoring. It is important that the individual doing the monitoring has the appropriate experience and qualifications for the task. The monitoring cannot be completed by the individual(s) whose work is under review.
 - b. Frequency of the monitoring; i.e., weekly x 4, then q 2 weeks x 4, then monthly x 3. A plan for 'random' audits will not be accepted. Initial audits must be more frequent than monthly to meet the requirement for the follow-up.
 - c. Start date of the audits;
- Include dates when corrective action will be completed in column 5.

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

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

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

This agency is required to notify CMS Region X of the results of this survey. We are recommending that CMS impose the following remedy:

Denial of payment for new admissions effective as soon as notice requirements can be met. [42 CFR §488.417(a)]

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **June 6, 2014**, if substantial compliance is not achieved by that time.

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

If you believe these deficiencies have been corrected, you may contact Loretta Todd, R.N. or Lorene Kayser, L.S.W., Q.M.R.P., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0036, Phone #: (208) 334-6626, Fax #: (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. 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)

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2001-10 Long Term Care Informal Dispute Resolution Process
2001-10 IDR Request Form

This request must be received by **December 30, 2013**. If your request for informal dispute resolution is received after **December 30, 2013**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact us at (208) 334-6626.

Sincerely,



LORENE KAYSER, L.S.W., Q.M.R.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 # 135060	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 12/6/2013
NAME OF PROVIDER OR SUPPLIER CARIBOU MEMORIAL LIVING CTR		STREET ADDRESS, CITY, STATE, ZIP CODE 300 SOUTH 3RD WEST SODA SPRINGS, ID	
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		
F 204	<p>483.12(a)(7) PREPARATION FOR SAFE/ORDERLY TRANSFER/DISCHRG</p> <p>A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.</p> <p>In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency the State LTC ombudsman, residents of the facility, and the legal representatives of the residents or other responsible parties, as well as the plan for the transfer and adequate relocation of the residents, as required at §483.75(r).</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 discharged residents' belongings were accounted for at the time of discharge. This affected 1 of 1 (# 8) closed records reviewed. Findings included:</p> <p>Resident #8 was admitted to the facility on 3/12/13 with multiple diagnoses including hypertension and anxiety. The resident expired in the facility on 9/28/13.</p> <p>Review of the resident's Inventory of Personal Effects form did not provide evidence the resident's belongings were accounted for.</p> <p>On 12/5/13 at 8:35 AM, the Long Term Care Manager was interviewed regarding the belongings. She said the facility did not document the resident's belongings were returned but was sure the family had received them. At 11:40 AM, the Long Term Care Manager said she had checked with the nurse involved and found out the resident's grandson had picked up the resident's personal belongings and the family had donated the resident's clothes to the facility.</p> <p>On 12/5/13 at 11:45 AM, the Administrator, the Long Term Care Manager and Social Worker were informed of the issues. The facility did not provide any additional information.</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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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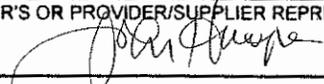
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135060	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/06/2013
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NAME OF PROVIDER OR SUPPLIER CARIBOU MEMORIAL LIVING CTR	STREET ADDRESS, CITY, STATE, ZIP CODE 300 SOUTH 3RD WEST SODA SPRINGS, ID 83276
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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 annual federal recertification survey of your facility. The surveyors conducting the survey were: Brad Perry, BSW, LSW, Team Coordinator Rebecca Thomas, RN The survey team entered the facility on December 2, 2013 and exited on December 6, 2013 Survey Definitions: ADL = Activities of Daily Living BIMS = Brief Interview for Mental Status cc = Cubic Centimeters CNA = Certified Nurse Aide LN = Licensed Nurse LPN = Licensed Practical Nurse MAR = Medication Administration Record MDS = Minimum Data Set assessment MG = Milligram PRN = As Needed RN = Registered Nurse	F 000		
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.	F 164		

RECEIVED
DEC 30 2013
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE CEO	(X6) DATE 12/27/13
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135060	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/06/2013
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F 164	<p>Continued From page 1</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to protect residents' personal medical information found during record review and medication pass observation. This was true for 2 of 8 residents (#s 1 and 5) and one random resident (#13) sampled for confidentiality of records. This failed practice created the potential to negatively affect the residents' psychosocial well-being for those who may not have wanted their medical information made public. Findings included:</p> <p>1. Resident #5 was admitted to the facility on 12/11/10 with multiple diagnoses of anterior wall myocardial infarction, atrial fibrillation, systolic heart failure, hypertension and dementia.</p> <p>On 12/3/13 at 8:50 AM, during the medication</p>	F 164	<p>F-164</p> <p>1. How will corrective action be accomplished for those residents found to have been affected by this deficient practice?</p> <p>a. An in-service was provided to all licensed staff on December 23, 2013 to inform them of this deficient practice affecting residents #1, #5, and #13 (attachment 1).</p> <p>2. How will the facility identify other residents having the potential to be affected by the same deficient practice?</p> <p>a. All residents have the ability to be affected by this deficient practice.</p> <p>3. Measures and/or specific changes put into place to ensure that this practice does not recur include:</p> <p>a. In-servicing at monthly staff meetings stating December 23, 2013.</p> <p>4. How will the facility monitor its corrective actions to ensure that the deficient practice will not recur?</p> <p>a. Starting the week of December 30th, 2013, the Long-Term Care Manager will observe staff performance weekly x 3 months by checking the MAR/TAR through med pass and treatment times to ensure it is closed when not in use (attachment 2).</p> <p>b. If the Long-Term Care Manager sees that the nurse has left the MAR/TAR open, immediate counseling to the responsible nurse will occur immediately.</p> <p>c. If the deficient practice continues by the same nurse, disciplinary action will occur.</p>

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NAME OF PROVIDER OR SUPPLIER CARIBOU MEMORIAL LIVING CTR		STREET ADDRESS, CITY, STATE, ZIP CODE 300 SOUTH 3RD WEST SODA SPRINGS, ID 83276		
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F 164	<p>Continued From page 2</p> <p>pass observation, RN #4 was observed to leave the resident's MAR, located on top of the medication cart in the Main TV Room, in full view of the 4 "Pink" ladies (volunteers) and 3 residents in the room. RN #4 left the medication cart and delivered a total of 14 medications to Resident #5 who was in her room. The first page of the MAR revealed the resident's name, patient number, room number, age, birth date, admit date, diagnoses, allergy information, a list of 7 medications along with the diagnosis for each medication, the physician's name and phone number.</p> <p>2. Resident #1 was admitted to the facility on 6/6/12 with multiple diagnoses of coronary artery disease, hypertension, dementia, insulin dependent diabetes mellitus, and depression.</p> <p>On 12/3/13 at 9:08 AM, during the medication pass observation, RN #4 was observed to leave the resident's MAR, located on top of the medication cart in the Main TV Room, in full view of 14 "Pink" ladies and 11 residents who had gathered to participate in an activity. RN #4 left the medication cart and delivered a total of 7 medications to Resident #1 who was in her room. The first page of the MAR revealed the resident's name, patient number, room number, age, birth date, admit date, diagnoses, allergy information, a list of 7 medications along with the diagnosis for each medication, the physician's name and phone number.</p> <p>On 12/3/13 at 9:15 AM, LN #4 was interviewed and stated she knew she shouldn't have left the MAR in full view of everyone in the Main TV Room and should have covered it up.</p>	F 164		

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F 164	<p>Continued From page 3</p> <p>On 12/5/13 at 8:40 AM, the Long Term Care Manager was made aware of the medication pass observations. No further documentation was provided by the facility.</p> <p>F 241 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY SS=E</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, it was determined the facility failed to ensure a resident was treated with dignity and respect when a staff member verbalized a work frustration to another staff member in the presence of the resident and clothing protectors were placed on residents without their permission and were not offered a cloth napkin. This was true for 4 of 8 sampled residents (#s 2-4 & 7), 5 random residents (#s 9-13), and all other residents observed during meals. This practice created the potential to negatively affect the residents' self-worth and self-esteem. Findings included:</p> <p>1. On 12/3/13 at 1:30 PM C.N.A. #1 was seen walking down the hallway complaining to two other staff members about a verbal altercation which occurred that day with a dietary aide. There were no residents in the area at the time C.N.A. #1 told the others about the incident.</p> <p>At 1:35 PM C.N.A. #1 and C.N.A. #2 were</p>	F 164 F 241	<p>F-241</p> <p>1. How will corrective action be accomplished for those residents found to have been affected by this deficient practice?</p> <p>a. residents 2-4, 7, and 9-12 are now offered a choice between courtesy covers, cloth napkins, or no cover at all at each meal.</p> <p>b. The employee responsible for talking about personal issues in front of the residents has been counseled and was given her one and only warning to not let it occur again. She stated understanding.</p> <p>c. Social Services spoke with resident #7 on 12/4/2013 to determine if there were any issues based on the staff talking about personal issues in front of resident #7 (attachment 25).</p> <p>2. How will the facility identify other residents having the potential to be affected by the same deficient practice?</p> <p>a. All residents have the potential to be affected by this deficient practice.</p> <p>3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</p> <p>The Long-Term Care Manager will implement measures to ensure this practice does not recur including:</p> <p>a. In-service done on December 23rd for all licensed and unlicensed staff regarding offering the choice of a courtesy cover, cloth napkin, or no cover at all (attachment 3)</p> <p>b. In the same in-service, staff were all advised to not talk about personal issues in front of residents (attachment 3).</p>	

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F 241	<p>Continued From page 4</p> <p>observed in Resident #7's room with the door opened. The resident was in her wheelchair and appeared to be waiting for the C.N.A.s to assist her. C.N.A. #1 stood behind and to the left side of Resident #7 and C.N.A. #2 stood to the right of the resident. C.N.A. #1 told C.N.A. #2 of the verbal altercation and stated, "I'm sick of it...I'm going to say something about it." C.N.A. #2 did not attempt to redirect C.N.A. #1 from discussing the issue in front of the resident. It appeared the aides were about to provide care needs for the resident, but appeared to be delayed as C.N.A. #1 retold the story to C.N.A. #2 instead. C.N.A. #1 then closed the door to the room.</p> <p>On 12/3/13 at 1:45 PM C.N.A. #1 was interviewed regarding the incident. C.N.A. #1 said prior to assisting Resident #7 and while in the resident's room, she told C.N.A. #2 about a verbal altercation she had with a dietary aide which took place after lunch. When asked if the resident had asked her to discuss the incident in the resident's presence, she stated, "No."</p> <p>On 12/5/13 at 9:05 AM the Long Term Care Manager was interviewed regarding the issue. She asked the surveyor, "Were they [C.N.A. #1 & #2] aware you were there?" The surveyor answered in the affirmative and then the Manager stated, "I will take care of that."</p> <p>2. On 12/3/13 during the breakfast meal observation the following were observed: *8:02-8:11 AM- R.N. #4 put a clothing protector on Resident #9 without asking or offering the resident a cloth napkin. C.N.A. #3 put a clothing protector on Resident #13 without asking or offering the resident a cloth napkin. *8:11 AM- L.P.N. #5 put a clothing protector on</p>	F 241	<p>4. How will the facility monitor its corrective actions to ensure that the deficient practice will not recur?</p> <p>The Long Term Care Manager will monitor corrective actions to ensure the effectiveness of these actions including</p> <p>a. Observing staff performance weekly x 3 months to ensure cloth napkins are being offered at meal times. This observance will start the week of December 30, 2013 (attachment 2).</p> <p>b. Observing staff performance at different times throughout the day on a weekly basis x 3 months to ensure staff are not talking about personnel issues in front of residents. This observance will start the week of December 30, 2013</p>		

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F 241	<p>Continued From page 5</p> <p>Resident #10 without asking or offering the resident a cloth napkin.</p> <p>*8:16 AM- R.N. #4 put a clothing protector on Resident #11 without asking or offering the resident a cloth napkin.</p> <p>On 12/3/13 at 11:55 AM during the lunch meal observation C.N.A. #3 asked Resident #12 if she wanted a clothing protector on, but did not offer a cloth napkin. At 12:17 PM C.N.A. #3 told Resident #4, "We're going to get some lunch," and then proceeded to place a clothing protector on the resident without asking or offering the resident a cloth napkin.</p> <p>On 12/4/13 from 5:58-6:06 PM during the dinner meal observations similar findings were observed with C.N.A. #6 and L.P.N. #s 7 & 8 with Resident #s 2, 4, & 12.</p> <p>On 12/5/13 at 9:00 AM the Long Term Care Manager was interviewed regarding the clothing protector issue and she stated, "We put them on them." When asked if the facility had cloth napkins, she said, "I don't know." She said they will begin offering napkins if they have them.</p> <p>On 12/5/13 at 10:50 AM the Dietary Manager was interviewed regarding the clothing protector issue and she said they use the cloth napkins on Sundays.</p> <p>Interpretive guidance at F241 document facilities should be, "Promoting resident independence and dignity in dining such as avoidance of: ...-Bibs (also known as clothing protectors) instead of napkins (except by resident choice)."</p> <p>On 12/5/13 at 11:45 AM the Administrator, the</p>	F 241		

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F 241	Continued From page 6 Chief Nursing Officer, the Long Term Care Manager, and Social Worker were informed of the dignity and clothing protector issues. No further information was provided by the facility.	F 241			
F 273 SS=D	483.20(b)(2)(i) COMPREHENSIVE ASSESSMENT 14 DAYS AFTER ADMIT A facility must conduct a comprehensive assessment of a resident within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or for therapeutic leave.) This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to complete an admission assessment within 14 days after admission for 1 of 8 (#4) sampled residents. This could potentially cause the resident's clinical condition to decline if care area triggers on the assessment were not identified and care planned accordingly. Findings included: Resident #4 was admitted to the facility on 7/13/13 and readmitted on 10/14/13 with multiple diagnoses including dementia, history of falls and right hip pain. Resident #4's original Admission MDS Assessment had an Assessment Reference Date of 7/19/13 and section C of the MDS contained that same date. However, the completion date of the MDS was documented as 9/12/13.	F 273	F-273 1. How will corrective action be accomplished for those residents found to have been affected by this deficient practice? a. This MDS has been completed and transmitted to state. It was late and there is nothing to do at this time to change it for this specific MDS. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice? a. All residents have the potential to be affected by this deficient practice. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? The MDS Coordinator will implement measures to ensure that this practice does not recur including: a. The MDS Coordinator will closely monitor dates of her MDS calendar to ensure all MDS data is entered by appropriate personnel on the dates listed on the MDS cover page. b. If the MDS Coordinator finds that the sections are not completed on the day they are due, she will speak with the person	12/26/13	

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F 273	<p>Continued From page 7</p> <p>On 12/5/13 at 9:15 AM the MDS Coordinator was interviewed regarding the completion date. She stated Social Services had been behind on paperwork which held up the completion date.</p> <p>On 12/5/13 at 9:40 AM the Social Worker was interviewed regarding the delay. She stated, "The interviews were done on the date reported," on the MDS, however the rest of the charting and information needed for the MDS assessment had not been completed and she stated, "I hadn't given it to them [MDS Coordinator and Long Term Care Manager]."</p> <p>On 12/5/13 at 11:45 AM the Administrator, the Chief Nursing Officer, the Long Term Care Manager, and Social Worker were informed of the MDS issues. No further information was provided by the facility.</p> <p>483.20(b)(2)(iii) COMPREHENSIVE ASSESS AT LEAST EVERY 12 MONTHS</p> <p>A facility must conduct a comprehensive assessment of a resident not less than once every 12 months.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to complete a comprehensive annual assessment within 366 days for 1 of 8 (#2) sampled residents. This failure could potentially affect the resident's clinical condition to decline if care area triggers on the assessment were not identified and care planned accordingly. Findings included:</p>	F 273	<p>responsible and if they are unable to complete their interviews/sections by the due date, the MDS Coordinator will complete them.</p> <p>c. The Social Worker will complete her interviews and turn the response in to the MDS Coordinator. She will then work on her assessments so if she is delayed on her assessments, the MDS portion will still be completed in the time frame allotted by the federal/state guidelines.</p> <p>4. How will the facility monitor its corrective actions to ensure that the deficient practice will not recur? The Long Term Care Manager will monitor corrective actions to ensure the effectiveness of these actions, including:</p> <ul style="list-style-type: none"> a. Concurrent monthly audits of MDS dates and completion will be done each month and turned in at the monthly Living Center QA meeting for review (attachment 4). b. These audits will occur monthly x 6 months. <p>F-275</p> <p>1. How will corrective action be accomplished for those residents found to have been affected by this deficient practice?</p> <ul style="list-style-type: none"> a. This MDS has been completed and transmitted to state. It was late and there is nothing to do at this time to change it for this specific MDS. <p>2. How will the facility identify other residents having the potential to be affected by the same deficient practice?</p> <ul style="list-style-type: none"> a. All residents have the potential to be affected by this deficient practice.
F 275 SS=D		F 275	

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F 275	<p>Continued From page 8</p> <p>Resident #2 was admitted to the facility on 7/19/10 with multiple diagnoses including pneumonia, hypertension, malaise, fatigue, chronic pain, hypothyroidism and depression.</p> <p>The resident's Comprehensive MDS Assessment had an Assessment Reference Date of 7/2/13, however, the completion date of the MDS was documented as 9/12/13. The resident's previous Comprehensive MDS Assessment was dated 7/10/12.</p> <p>On 12/4/13 at 9:15 AM, the Long Term Care Manager was interviewed about the delay and she stated, "yes, that is right, we had some delay."</p> <p>On 12/5/13 at 9:15 AM the MDS Coordinator was interviewed regarding the completion date. She stated Social Services had been behind on paperwork which held up the completion date.</p> <p>On 12/5/13 at 9:40 AM the Social Worker was interviewed regarding the delay. She stated, "The interviews were done on the date reported," on the MDS, however the rest of the charting and information needed for the MDS assessment had not been completed and she stated, "I hadn't given it to them [MDS Coordinator and Long Term Care Manager]."</p> <p>On 12/5/13 at 11:45 AM the Administrator, the Chief Nursing Officer, the Long Term Care Manager, and Social Worker were informed of the MDS issues. No further information was provided by the facility.</p>	F 275	<p>c. The Social Worker will complete her interviews and turn the response in to the MDS Coordinator. She will then work on her assessments so if she is delayed on her assessments, the MDS portion will still be completed in the time frame allotted by the federal/state guidelines.</p> <p>4. How will the facility monitor its corrective actions to ensure that the deficient practice will not recur? The Long Term Care Manager will monitor corrective actions to ensure the effectiveness of these actions, including:</p> <ol style="list-style-type: none"> Concurrent monthly audits of MDS dates and completion will be done each month and turned in at the monthly Living Center QA meeting for review (attachment 4). These audits will occur monthly x 6 months. 	
F 309	483.25 PROVIDE CARE/SERVICES FOR	F 309		

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F 309
SS=D

Continued From page 9
HIGHEST WELL BEING

Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview, it was determined the facility failed to ensure residents received the necessary care and services to attain or maintain their highest practicable well-being. This was true for 1 of 8 sampled residents (#5) for following physician orders. Failure to obtain and/or document vital signs as ordered placed the resident at risk to not receive appropriate care related to cardiac disease. Findings included:

Resident #5 was admitted to the facility on 12/11/10 with multiple diagnoses of anterior wall myocardial infarction, atrial fibrillation, systolic heart failure, hypertension and dementia.

The resident's Physician's Orders for the month of December 2013, documented an order "Vital Signs Q [every] day" with a start date of 5/14/11.

Review of the resident's medical record revealed vital signs were taken daily for the month of October. The month of November, however, documented vital signs were only taken 4 times during the month on 11/4/13, 11/10/13, 11/23/13 and 11/24/13. The month of December only

F 309

F-309

1. How will corrective action be accomplished for those residents to have been affected by this deficient practice?
The Long-Term Care Manager has implemented corrective action for resident #5 affected by this practice, including:
a. Changing the vital sign order to read vital signs Q week (attachment 5).

2. How will the facility identify other residents having the potential to be affected by the same deficient practice?
a. All residents have the potential to be affected by the same deficient practice.

3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?
The Long-Term Care Manager will implement measures to ensure that this practice does not recur, including:
a. Completing triple checks monthly to ensure all vital sign orders are captured correctly on the current recaps.
b. Review new admission orders to ensure vital signs are ordered per facility protocol. If the physician orders more frequent vitals than every week, a stop date will be documented on order and noted on MAR/TAR.

4. How will the facility monitor its corrective actions to ensure that the deficient practice will not recur?
The Long-Term Care Manager will monitor corrective actions to ensure the effectiveness of these actions, including:
a. Performing weekly quality assurance on vital signs x 3 months to ensure they are being done as ordered (attachment 6). This QA will start the week of December 30, 2013.

12/9/13

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F 309	Continued From page 10 documented vital signs were taken on 12/1/13. On 12/5/13 at 8:35 AM, the Long Term Care Manager was interviewed and stated the staff were not taking the vital signs as ordered by the physician for this resident. She verified the month of October was documented, but the months of November and December were not being documented. On 12/5/13 at 11:45 AM., the Administrator, the Long Term Care Manager and Social Worker were informed of the issues. The facility did not provide any additional information.	F 309		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review it was determined the facility did not ensure 1 of 3 residents sampled for falls (#4) was provided care to prevent accidents. Resident #4 was harmed when she fell and sustained a left hip and left wrist fracture after a tab alarm was not turned on prior to her fall. The facility also failed to determine the cause of falls and provide adequate care plan interventions, despite a history of recent falls. In addition, one can of	F 323	F-323 1. How will corrective action be accomplished for those residents found to have been affected by the deficient practice? a. Resident #4 passed away on 12/11/2013 due to old age. b. In-service provided on December 23, 2013 to remind staff to not leave disinfectant out where residents can reach it. Even though residents did not get the can left out during survey, does not mean that they won't ever get to it if it's left out again. They were reminded to always lock cleaning items up. 2. How will the facility identify other residents having the potential to be affected by this practice? All residents have the potential to be affected by this deficient practice.	12/24/13

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F 323	<p>Continued From page 11</p> <p>disinfectant spray was found in an unlocked cabinet in an unlocked tub room. Findings included:</p> <p>1. Resident #4 was admitted to the facility on 7/13/13 and readmitted on 10/14/13 with multiple diagnoses including dementia, history of falls and right hip pain.</p> <p>The resident's admission MDS assessment, dated 7/19/13, documented one fall since admission/entry or reentry or prior assessment and severe cognitive impairment, BIMs = 1.</p> <p>The resident's Fall/Safety Risk/Elopment [sic] Risk Care Plan, dated 7/13/13, documented the following interventions:</p> <ul style="list-style-type: none"> * Keep call light with reach; encourage use; * Answer call light quickly to anticipate needs; * Check on resident frequently if unable to use call light; * PT [Physical Therapy] eval[uation] on admit and PRN; * Alarm (pressure); * Ensure resident has non-skid footwear; * Keep environment clean and clutter free. <p>A facility "Incident Report" dated 7/14/13, indicated the resident fell on 7/14/13 at 3:47 AM. The description of the event documented the following:</p> <p>"CNA found resident on floor leaning against the bed. This nurse responded right away, who was concerned the R[ight] FX [fracture] lower leg was bent [with] knee facing toward L[eft] knee. Inner part of foot was on the floor. She denied hitting head. She has no noted new bruising."</p> <p>Under the section titled, 'Describe what follow-up, if needed, has or will take place' the following was</p>	F 323	<p>3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</p> <p>Long-Term Care Manager will implement measures to ensure that this practice does not recur, including:</p> <ul style="list-style-type: none"> a. In-serviced staff on December 23, 2013 regarding importance of checking alarm on hourly rounds and ensuring they are hooked up correctly (attachment 7) b. Implementing the new Fall Scene Investigation report after every fall to determine cause of fall and allow for more thorough care planning based on cause (attachment 8). c. New care plan fall template to ensure additional interventions are added in addition to current interventions after each fall (attachment 9) d. Members of IDT to conduct Fall Huddles on the next working day after a fall to initiate changes to plan of care. e. In-serviced staff on December 23, 2013 to initiate Q ½ hour visual checks x 24 hours after a fall with any resident (attachment 10). f. In-service provided on December 23, 2013 to remind staff to not leave disinfectant out where residents can reach it. Even though they did not get the can left out during survey, does not mean that they won't ever get to it (attachment 11). g-Housekeeping manager in-serviced her staff on December 24, 2013 to inform them that they need to be on the lookout for cleaning solutions that are left out and if they do see any, they are to lock them up immediately (attachment 12).

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Continued From page 12 documented:
 * X-ray done;
 * No negative outcome;
 * Pressure alarm in bed;
 * Floor mats placed;
 * Tabs when in w/c.

The resident's 72 Hour Care Plan For Falls initiated on 7/14/13 and resolved on 7/18/13, documented, in part, the following interventions:
 * Alert charting with full nursing assessment q [every] shift;
 * Bed locked and in lowest position;
 * Motion sensor in place;
 * Mats to side of bed;
 * Increased supervision;
 * Monitor bed/chair position frequently.
 Note: These temporary interventions were in addition to the 7/13/13 Care Plan interventions.

A facility "Incident Report" dated 7/19/13, indicated the resident fell on 7/19/13 at 11:05 AM. The description of the event documented the following:
 "Resident slipped out of recliner in TV r[oom]m...Res[ident] stated she needs to go. Put on commode. Voided 100cc."
 Under the section titled, 'Accident investigation-Manager/Supervisor Follow-up (completion of this section is mandatory) What corrective action has been taken to prevent similar accidents (please check all that apply)' was left blank.
 Under the section titled, 'Describe what follow-up, if needed, has or will take place' the report documented, "No injury."

The resident's 72 Hour Care Plan For Falls initiated 7/19/13 and resolved on 7/23/13,

F 323

4. How will the facility monitor its corrective actions to ensure that the deficient practice will not recur?
 LTC Manager will monitor corrective actions to ensure the effectiveness of these actions, including:
 a. Continuing with monthly QA on hourly rounds to ensure hourly rounds are being done regularly.
 b. Reviewing Fall Scene Investigation Report after a fall to ensure its accuracy and counseling the staff member who signs the Fall Scene Investigation Report if it is not done in its entirety.
 c. Reviewing care plans after falls to ensure new interventions are placed in care plan.
 d. Review Q ½ hour visual checks after they are supposed to be complete to ensure they are filled out correctly. Counsel staff if they are not done correctly.
 e. Weekly checks x 3 months to facility to ensure no cleaning solutions/disinfectants are left out. These checks will begin the week of December 30, 2013 (attachment 2).

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F 323 Continued From page 13 documented, in part, the following interventions:
 * Alert charting with full nursing assessment q shift;
 * Assist to the rest room and with peri care/incontinent cares prn;
 * Encourage use of proper footwear and assistive devices as appropriate;
 * Monitor bed/chair position frequently.
 Note: These temporary interventions were in addition to the 7/13/13 Care Plan interventions.

The resident's Fall Care Plan initiated on 9/12/13 documented the following interventions:
 * Call light within reach while in room;
 * Answer call light quickly to anticipate needs;
 * Allow independence but provide supervision and assistance as needed with ADL's;
 * Keep environment clean and clutter free;
 * Report any falls or near falls.
 The resident's Exit seeking/elopment [sic] Care Plan initiated on 9/27/13 documented an intervention to provide, "Personal safety alarms."

The resident's General Notes documented by an LN on 10/4/13 at 7:30 AM the following: "Resident pressure sensor went off. Went and helped pt [patient] up and pt c/o [complained of] pain at upper thigh. Took her out to living room would not go back to bed [sic]. Crawled out of Recliner while getting her medication ran to help her alarm was going off again [sic]."

The resident's 10/7/13 Fall Risk Assessment documented the resident as a high fall risk.

A facility "Incident Report" dated 10/9/13 indicated the resident fell on 10/9/13 at 2:03 PM. The description of the event documented the following:

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F 323 Continued From page 14

"Didn't see resident get out of chair. Pressure sensor on but alarm not on. Saw resident walking backwards, flinging arms out trying to catch her balance. She was headed to the wall. I ran towards her but was unable to get to her to assist her to floor. She hit the floor [with] L hip first, then trying to brace herself she landed on L wrist. She didn't hit her head...Sent to ER [emergency room]..."

The report had the question, "Alarm System on?" The section contained a check mark in the "NO" area along with a handwritten note which documented, "Was not turned on."

Local hospital Pelvic and Left Forearm x-ray reports both dated 10/10/13 documented, "There is an acute intertrochanteric fracture of the left hip." "There is a fracture of the ulnar styloid and there is a fracture of the distal radial metaphysis." Note: Hospital records documented the hip fracture required surgical repair and the wrist fracture required a splint.

On 12/4/13 at 11:40 AM, the Long Term Care Manager was interviewed regarding Resident #4's history of falls. When asked about the 72 Care Plans initiated after the 7/14 and 7/19 falls, she said the facility had used temporary care plans after the falls for 72 hours and then reverted back to the care plan on file prior to the fall. When asked how the facility would know if the temporary care plans worked, she stated, "If she [the resident] didn't fall again." When asked why the 7/19/13 Incident Report was left blank under the 'Accident investigation-Manager/Supervisor Follow-up' section and "No injury" was documented under the section 'Describe what follow-up, if needed, has or will take place', she stated, "That's me...I

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F 323	<p>Continued From page 15</p> <p>have no idea...I don't know why I didn't put more." She also said the facility was starting a root cause analysis project to better understand falls and fall prevention.</p> <p>When asked about the nurse's note regarding the resident crawling out of the recliner, she said she would check with the nurse who wrote the note to clarify it.</p> <p>When asked to read the 10/9/13 Incident Report where it documented the alarm not being on, she stated, "The motion sensor is not an intervention if not applied correctly." But stated she would also clarify this comment with the nurse who charted it.</p> <p>On 12/4/13 at 3:35 PM, the Long Term Care Manager reported back to the surveyor, she had spoken to the nurse who charted both incidents. She said the crawling out of the recliner comment was the nurse's way of saying the resident had been up and down out of the recliner that day. When the Long Term Care Manager was asked what interventions were attempted at that time, she said the nurse did not implement any interventions at that time.</p> <p>With regards to the 10/9/13 fall, the Long Term Care Manager said the nurse told her the resident's chair pressure alarm was a different model type than the resident had been using and it did not work when the resident fell because, "It was not hooked up right."</p> <p>On 12/5/13 at 11:45 AM, the Administrator, Long Term Care Manager, and Social Worker were informed of the issue. No further information was provided by the facility.</p> <p>The facility did not ensure they kept the resident safe from falls, even though she was a high fall</p>	F 323		

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135060	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/06/2013
NAME OF PROVIDER OR SUPPLIER CARIBOU MEMORIAL LIVING CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 300 SOUTH 3RD WEST SODA SPRINGS, ID 83276		
(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	Continued From page 16 risk with two prior falls in the facility. The resident fell a third time, resulting in harm to the resident when she sustained left hip and left wrist fractures. 2. On 12/2/13 at 5:17 PM an unlocked tub room across from room 219 was observed. Next to the bathtub was a closed plastic cabinet on the floor with a padlock found on top of the cabinet. The surveyor opened the unlocked cabinet and found an assortment of soap and shampoo. On the top shelf of the cabinet a can of disinfectant spray was found which read, "Hazardous to Humans-Harmful if swallowed." The surveyor was able to alert the facility Social Worker, who was outside of the tub room, of the hazard. She stated, "Not good at all. That's a problem." At 5:25 PM the Social Worker locked the cabinet with the disinfectant spray in it, with the lock from atop the cabinet. After the hazard was secured, the surveyor left the tub room. At 5:30 PM the Social Worker approached the surveyor to say she had completely removed the disinfectant spray from the cabinet, so it would not be an issue again. On 12/3/13 at 4:30 PM the Administrator, the Chief Nursing Officer, and Social Worker were informed of the issue. No further information was provided by the facility.	F 323			
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections;	F 328			

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F 328	<p>Continued From page 17</p> <p>Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure residents who use oxygen (O2) were monitored as ordered by the physician. This was true for 2 of 8 (#s 1 and 2) sampled residents for documentation of O2 saturations. This deficient practice created the potential for more than minimal harm should residents have a drop in O2 saturations causing them to become anxious, confused and/or experience respiratory distress. Findings included:</p> <p>1. Resident #1 was admitted to the facility on 6/6/12 with multiple diagnoses of coronary artery disease, hypertension, dementia, insulin dependent diabetes mellitus, and depression.</p> <p>The resident's most recent Quarterly MDS Assessment, dated 9/4/13, documented in Section O the resident received O2 therapy.</p> <p>The resident's care plan for the problem "requires supervision and assist with some ADLs as needed," with a start date of 6/26/13 and updated on 9/20/13, documented an intervention "Oxygen therapy as ordered." Additionally, a care plan for the problem "difficulty with breathing with increased anxiety again. Her saturation level was</p>	F 328	<p>F-328</p> <p>1. How will corrective action be accomplished for those residents found to have been affected by the deficient practice? The Long-Term Care Manager has implemented corrective actions for residents 1 and 2 affected by this practice, including: a. Changing recapitulation order for the affected residents to read Oxygen Saturation every day instead of every shift (attachment 13 and 14).</p> <p>2. How will the facility identify other residents having the potential to be affected by this practice? a. All residents have the potential to be affected by this deficient practice.</p> <p>3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? The Long-Term Care Manager will implement measures to ensure that this practice does not recur, including: a. Completing triple checks monthly to ensure all new orders are captured correctly on the current recaps. b. Review new admission orders to ensure vital signs (including oxygen saturation) are ordered per facility protocol. If the physician orders more frequent oxygen saturation checks than every day, a stop date will be ordered and placed on the TAR.</p>	12/26/13

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F 328 Continued From page 18

low, in the 60s," with a start date of 7/25/12 and a review date of 9/20/13, documented the following interventions:

- * O2 as ordered. Titrate as needed to keep sats (saturation levels) greater than 88%.
- * Keep family and physician notified of condition as needed.

Resident #1's Physician Orders, dated December 2013, documented in the Treatment Orders the following oxygen orders:

- * O2 1-5 L/NC (liters via nasal cannula) to keep sats >88% with a start date of 6/6/12.
- * O2 sats Q (every) shift with a start date of 6/6/12.

On 12/5/13 at 8:35 AM, the Long Term Care Manager was interviewed regarding the monitoring of Resident #1's O2 saturations. She printed the Resident Vitals Chart sheet which documented the "Pulse Oxygen Saturation" which indicated the saturations were only being monitored daily and not every shift as ordered by the physician. Additionally, there were 9 days without any O2 saturation documentation for the month of November 2013. The Long Term Care Manager stated it looked like her staff were not documenting the O2 saturation as ordered by the physician and she needed to have a meeting with her staff.

2. Resident #2 was admitted to the facility on 7/19/10 with multiple diagnoses including pneumonia, hypertension, malaise, fatigue, chronic pain, hypothyroidism and depression.

The resident's most recent Quarterly MDS Assessment, dated 10/3/13, documented in Section O the resident received O2 therapy.

F 328

4. How will the facility monitor its corrective actions to ensure that the deficient practice will not recur?

The Long-Term Care Manager will monitor corrective actions to ensure the effectiveness of these actions, including:

- a. Performing weekly quality assurance on oxygen saturation levels x 3 months to ensure they are being done as ordered and per facility protocol (attachment 6).

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F 328	Continued From page 19 Resident #2's care plan for the problem of "Impaired mobility," with a start date of 9/12/13 and updated on 10/3/13, documented an intervention "Oxygen: 1-4 L/NC to keep sats >88%." Additionally, a care plan for the problem "Chronic lung issues related to being caught in a fire years ago," with a start date of 9/12/13 and a review date of 10/3/13, documented the following interventions: * "Oxygen therapy as ordered. * Notify physician of any lung issues that are uncontrolled or out of the norm." Resident #2's Physician Orders, dated December 2013, documented in the Treatment Orders the following O2 orders: * O2 at 1-4 Liters/NC to keep sats >88% with a start date of 7/15/11. * O2 Sats Q shift with a start date of 7/19/10. On 12/5/13 at 8:35AM, the Long Term Care Manager was interviewed regarding monitoring of O2 saturations for Resident #2. She printed the Resident Vitals Chart sheet which documented the "Pulse Oxygen Saturation" which indicated the saturations were only being monitored daily and not every shift as ordered by the physician. Additionally, there were 8 days without any O2 saturation documentation for the month of November 2013. The Long Term Care Manager stated it looked like her staff were not documenting the O2 saturation as ordered by the physician and she would need to do some education. On 12/5/13 at 11:45 AM., the Administrator, the Long Term Care Manager and Social Worker were informed of monitoring the O2 saturation	F 328			

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F 328	Continued From page 20 issues. The facility did not provide any additional information.	F 328		
F 329 SS=D	<p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>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.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to consider the risk identified in the black box warning and did not provide adequate monitoring to ensure residents' drug regimens were free from unnecessary</p>	F 329	<p>F-329 1. How will corrective action be accomplished for those residents found to have been affected by the deficient practice? Members of the IDT (LTC Manager, CNO, Social Services and Pharmacy) implemented corrective action for residents 2, 3, and 5 affected by this practice, including: a. Having a Psychotropic Interdisciplinary Medication Review for the three affected residents on December 19, 2013. All psychotropic medications were reviewed for the three residents. b. Reviewed the Black Box Warning for residents with dementia (attachment 15). c. Based on this review, the team recommended to the physician that Resident #2 fluoxetine be titrated from 20mg to 10mg (Attachment 16). A black box warning for Resident #2 is not applicable. d. Based on this review, it was discussed that Resident # 3 has a significant history of Vertigo and receives meclizine as needed. Resident #3 often walks her head down and eyes closed likely due to dizziness. It was thought that maybe she is suffering from Meniere's disease and these symptoms are often controlled with Valium. The team recommended that the physician considers discontinuing her scheduled Xanax and starting Valium. We will continue with her current dose of Zoloft until the Valium is evaluated for effectiveness (attachment 17). A black box warning for Resident #3 was completed by the physician and signed by the legal representative (attachment 18). e. Based on this review, Resident #5 is not due for a GDR at this time (attachment 19). A black box warning for Resident #5 was completed by the physician and signed by the legal representative (attachment 20)</p>	12/30/13

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F 329	<p>Continued From page 21</p> <p>drugs. This was true for 3 of 8 (#2, 3 and 5) sampled residents. This created the potential for harm to residents as unnecessary drugs can lead to adverse reactions and health decline. Findings included:</p> <p>1. Resident #2 was admitted to the facility on 7/19/10 with multiple diagnoses including pneumonia, hypertension, malaise, fatigue, chronic pain, hypothyroidism and depression.</p> <p>The resident's Physician's Orders, dated December 2013, documented an order for "Fluoxetine (Prozac) 20 mg Cap[sul] One Q [every] Day PO [by mouth]" with a diagnosis of depression and a start date of 9/17/10. The resident's MAR documented the resident received the Fluoxetine as ordered.</p> <p>The resident's care plan for the problem of "At risk for drug related complications related to being on an antidepressant," dated 9/12/13 with a review date of 10/3/13, documented an intervention "GDR [gradual dose reduction] per policy."</p> <p>On 12/4/13 at 2:35 PM, the Long Term Care Manager was asked for documentation of a GDR dose reduction for Fluoxetine. She stated a GDR had not been attempted since 2011 and stated the resident's physician had written a note, dated 7/29/11, stating the resident was "currently stable on Fluoxetine. Please maintain her on this dose. She is mentally competent and does not want to discontinue the medication."</p> <p>Federal Guidance at F-329, under the heading "Considerations Specific to Psychopharmacological Medications (Other Than</p>	F 329	<p>2. How will the facility identify other residents having the potential to be affected by this practice?</p> <p>a. All residents who are on psychotropic medication and require a Gradual Dose Reduction have the potential to be affected by the deficient practice.</p> <p>b. All elderly residents who are prescribed an antipsychotic with a black box warning have the potential to be affected by this deficient practice.</p> <p>3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</p> <p>Members of the IDT will implement measures to ensure that this practice does not recur, including:</p> <p>a. Monthly Psychotropic Interdisciplinary Medication Reviews for all residents who are prescribed psychotropic medication starting December 30, 2013. These reviews cover name and type of medication, diagnosis target behaviors, non-pharmacological interventions, adverse effects, Pain, Labs, Risk/Benefit discussion, and GDR attempts. This review includes recommendations to the physician and the physician order section (attachment 21).</p> <p>b. This monthly review will include at a minimum: Social Services, CNO, LTC Manager and Pharmacist.</p>	
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F 329	<p>Continued From page 22</p> <p>Antipsychotics and Sedatives/Hypnotics)" states, "After the first year, a tapering should be attempted annually, unless clinically contraindicated."</p> <p>Resident #2's medical record did not include documentation the facility had considered a GDR since 7/29/11. The physician had not documented the clinical rationale for why an attempted dose reduction would impair the resident's function.</p> <p>2. Resident #5 was admitted to the facility on 12/11/10 with multiple diagnoses of anterior wall myocardial infarction, atrial fibrillation, systolic heart failure, hypertension and dementia.</p> <p>The resident's Physician's Orders, dated December 2013, documented an order for "Risperidone 0.5 mg Tab[let] One [tablet] Q HS [hour of sleep] PO" with a diagnosis of paranoia and a start date of 10/17/13. Additionally, there was an order for "Risperidone 0.25 mg Tab One Q TID [three times per day] PO PRN [as needed]" with a diagnosis of agitation/paranoia and a start date of 10/17/13. The resident's MAR documented the resident received the Fluoxetine as ordered.</p> <p>According to Wolters Kluwer/Lippincott Williams & Wilkins Nursing 2013 Drug Handbook, 33rd Edition, page 1194, under Nursing Considerations for Risperdal, the Black Box Warning states, "Fatal cardiovascular or infectious adverse events may occur in elderly patients with dementia. Drug isn't safe or effective in these patients."</p> <p>On 12/3/13 at 3:55 PM, the Chief Nursing Officer was interviewed regarding documentation of the risks and benefits for the Black Box Warning for</p>	F 329	<p>4. How will the facility monitor its corrective actions to ensure that the deficient practice will not recur?</p> <p>Social Services will monitor corrective actions to ensure the effectiveness of these actions, including:</p> <ul style="list-style-type: none"> a. Planning and conducting monthly psychotropic medication reviews with other IDT members. b. Social Services will fill out the Psychotropic Interdisciplinary Review form at the monthly meeting. 	

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F 329	Continued From page 23 Risperidone. She stated "I don't know that it is in there." She stated the Black Box Warning had not been explained to the resident's family or her guardian. Resident #5's medical record did not document the facility had considered or informed the resident/family of the Black Box Warning. 3. Resident #3 was admitted to the facility on 2/1/12 with multiple diagnoses including Alzheimer's disease, depression, and anxiety. Resident #3's December 2013 MAR documented, with a start date of 10/23/13, "Risperidone .5 MG Tab[let] One Tab Q [every] AM PO [by mouth]" with a diagnosis of physical aggression, delusions and agitation. The MAR documented the resident received the medication as ordered. The Resident's medical record contained a document titled "Consent to Use Psychoactive Medications" and was signed by the resident's POA and contained common side effects listed for psychoactive medications, however, the document did not contain a warning of increased risk of death in the elderly. On 12/3/13 at 4:25 PM the Chief Nursing Officer was interviewed regarding if the risk of death in the elderly had been discussed with the POA and she stated, "it was not." On 12/3/13 at 4:30 PM, the Administrator, the Chief Nursing Officer, and the Social Worker were informed of the medication issue. No further information was provided.	F 329			
F 514	483.75(l)(1) RES	F 514			

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F 514 SS=D	Continued From page 24 RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to maintain accurate, complete and organized clinical records on each resident. This was true for 2 of 8 sampled residents (#s 1 and 2) reviewed for clinical records. This created the potential for medical decisions to be based on inaccurate information. Finding included: 1. Resident #2 was admitted to the facility on 7/19/10 with multiple diagnoses including pneumonia, hypertension, malaise, fatigue, chronic pain, hypothyroidism and depression. Resident #2's Physician's Orders (Recapitulation), dated December 2013, documented an order with a start date of 11/4/13, "Irrigate Bladder with 2 60 ml (milliliter) syringes of sterile water flush and aspirate several times to keep foley open." However, there was no	F 514	F-514 1. How will corrective action be accomplished for those residents found to have been affected by the deficient practice? Long Term Care Manager implemented corrective actions for Resident #1 and #2 affected by this deficient practice, including: a. Clarification order written for daily bladder irrigation for resident #2 (attachment 22). b. CNO removed documentation for Resident #13 out of Resident #1's chart. 2. How will the facility identify other residents having the potential to be affected by this practice? All residents have the potential to be affected by this deficient practice. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? The Long-Term Care Manager will implement measures to ensure that this practice does not recur, including: a. In-service on December 23, 2013 to all licensed staff regarding clarification of orders and ensuring that the frequency of the order is included (attachment 23) b. In-service also included reminding everyone to place documentation in the appropriate chart and if they see something in the wrong chart to please place it in the correct chart (attachment 24).	12/26/13

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F 514	<p>Continued From page 25</p> <p>documentation as to how often to irrigate the bladder.</p> <p>On 12/4/13 at 2:35 PM, the Long Term Care Manager was interviewed and asked about the bladder irrigation order. She stated she would need to look at the original order. She found the original order which documented to irrigate the bladder daily.</p> <p>On 12/5/13 at 11:45 AM, the Administrator, the Long Term Care Manager and Social Worker were informed of the inaccuracy of the Physician's Orders (Recapitulation) for the month of December 2013. The facility did not provide any additional information.</p> <p>2. Resident #1 was admitted to the facility on 6/6/12 with multiple diagnoses of coronary artery disease, hypertension, dementia, insulin dependent diabetes mellitus, and depression.</p> <p>Resident #1's record review, on 12/3/13 at 2:00 PM, documented a Physician Communication Sheet, dated 10/14/13, for random Resident #13.</p> <p>On 12/3/13 at 2:05 PM, Resident #1's medical record was shown to the Chief Nursing Officer who stated, "Oh dear, we will remove it and put it in the correct chart."</p>	F 514	<p>4. How will the facility monitor its corrective actions to ensure that the deficient practice will not recur?</p> <p>Long-Term Care Manager will monitor corrective actions to ensure the effectiveness of these actions, including:</p> <p>a. Performing triple checks monthly to ensure that all applicable orders have frequency listed.</p> <p>b. The ward clerk will do weekly checks on different charts x 3 months to ensure that documentation is placed in the correct charts.</p>	

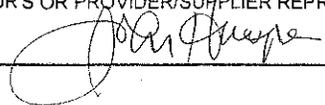
Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001110	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/06/2013
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	<p>16.03.02 INITIAL COMMENTS</p> <p>The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2.</p> <p>The following deficiencies were cited during the State licensure survey of your facility.</p> <p>The surveyors conducting the survey were: Brad Perry, BSW, LSW, Team Coordinator Rebecca Thomas, RN</p>	C 000	<p style="text-align: center;">RECEIVED DEC 30 2013 FACILITY STANDARDS</p> <p style="text-align: center;">See F-164</p> <p style="text-align: center;">See F-241</p>	
C 124	<p>02.100.03,c,viii Confidentiality of Records</p> <p>viii. Is assured confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in case of his transfer to another health care facility, or as required by law or third-party payment contract; This Rule is not met as evidenced by: Please refer to F-164 as it relates to privacy and confidentiality of clinical records.</p>	C 124		
C 125	<p>02.100.03,c,ix Treated with Respect/Dignity</p> <p>ix. Is treated with consideration, respect and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; This Rule is not met as evidenced by: Refer to F241 regarding resident dignity and clothing protectors.</p>	C 125		

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



TITLE

CEO

(X6) DATE

12/27/13

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001110	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/06/2013
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C 147	Continued From page 1	C 147		
C 147	<p>02.100,05,g Prohibited Uses of Chemical Restraints</p> <p>g. Chemical restraints shall not be used as punishment, for convenience of the staff, or in quantities that interfere with the ongoing normal functions of the patient/resident. They shall be used only to the extent necessary for professionally accepted patient care management and must be ordered in writing by the attending physician.</p> <p>This Rule is not met as evidenced by: Please refer to F-329 as it refers to Black Box Warnings.</p>	C 147	See F-329	
C 159	<p>02.100,09 RECORD OF PTNT/RSDNT PERSONAL VALUABLES</p> <p>09. Record of Patient's/Resident's Personal Valuables. An inventory and proper accounting shall be kept for all valuables entrusted to the facility for safekeeping. The status of the inventory shall be available to the patient/resident, his conservator, guardian, or representative for review upon request.</p> <p>This Rule is not met as evidenced by: Please refer to F-204 as it relates to documentation of belongings after discharge.</p>	C 159		
C 342	<p>02.108,04,b,ii Toxics Stored Under Lock and Key</p> <p>ii. All toxic chemicals shall be properly labeled and stored under lock and key.</p> <p>This Rule is not met as evidenced by:</p>	C 342	See F-323	

Bureau of Facility Standards

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C 342	Continued From page 2 Refer to F323 regarding disinfectant found in an unlocked cabinet.	C 342		
C 784	02.200,03,b Resident Needs Identified b. Patient/resident needs shall be recognized by nursing staff and nursing services shall be provided to assure that each patient/resident receives care necessary to meet his total needs. Care shall include, but is not limited to: This Rule is not met as evidenced by: Please refer to F-309 as it relates to highest practical care.	C 784	See F-309	
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: Please refer to F-328 as it relates to oxygen therapy.	C 788	See F-328	
C 790	02.200,03,b,vi Protection from Injury/Accidents vi. Protection from accident or injury; This Rule is not met as evidenced by: Refer to F323 regarding a resident fall with injury.	C 790	See F-323	
C 820	02.201,01,a 30-Day Review of All Meds a. Reviewing the medication profile for each individual patient at least	C 820	See F-329	

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C 820	Continued From page 3 every thirty (30) days. The attending physician shall be advised of drug therapy duplication, incompatibilities or contraindications. This Rule is not met as evidenced by: Please refer to F-329 as it refers to gradual dose reduction.	C 820		
C 881	02.203,02 INDIVIDUAL MEDICAL RECORD 02. Individual Medical Record. An individual medical record shall be maintained for each admission with all entries kept current, dated and signed. All records shall be either typewritten or recorded legibly in ink, and shall contain the following: This Rule is not met as evidenced by: Please refer to F-514 as it relates to complete and accurate documentation.	C 881	See F-514	