IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
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3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
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March 4, 2016

Bonnie Sorensen, Administrator
Countryside Care & Rehabilitation
1224 8th St
Rupert, ID 83350

Provider #: 135064

Dear Ms. Sorensen:

On **February 19, 2016**, a 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 one that comprises a pattern that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567 listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided 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." **Please provide ONLY ONE completion date for each federal and state tag (if applicable) 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 the Form CMS-2567 and State Form (if applicable), Statement of Deficiencies and Plan of Correction in the spaces provided and return the original(s) to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **March 17, 2016**. Failure to submit an acceptable PoC by **March 17, 2016**, may result in the imposition of civil monetary penalties by **April 6, 2016**.

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; and

- 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 the federal survey report, Form CMS-2567 and the state licensure survey report, State Form (if applicable).

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 **April 8, 2016 (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 **April 8, 2016**. A change in the seriousness of the deficiencies on **April 8, 2016**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **April 8, 2016** includes the following:

Denial of payment for new admissions effective **May 19, 2016**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying non-compliance, 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 **August 19, 2016**, 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, CMS will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 2; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. 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 **February 19, 2016** 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 non-compliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

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

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

- BFS Letters (06/30/11)

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

This request must be received by **March 17, 2016**. If your request for informal dispute resolution is received after **March 17, 2016**, 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 David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2.

Sincerely,

Nina Sanderson LSW

NINA SANDERSON, L.S.W., Supervisor
Long Term Care

NS/lj
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135064	A. BUILDING _____ B. WING _____	02/19/2016

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) COMPLETION DATE
F 000	INITIAL COMMENTS The following deficiencies were cited during the federal recertification survey conducted at the facility from February 16 to February 19, 2016. The surveyors conducting the survey were: Brad Perry, BSW, LSW, Team Coordinator Arnold Rosling, RN, BSN, QIDP Survey Definitions: BM = Bowel Movement cm = Centimeters CNA = Certified Nurse Aide ER = Emergency Room LN = Licensed Nurse MDS = Minimum Data Set assessment PRN = As Needed s/s = Signs and Symptoms W/C = Wheelchair	F 000		
F 166 SS=E	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on observations, Resident Group Interview, review of the facility's Complaint/Grievance policy, and staff interview, it was determined the facility did not ensure residents and staff were informed on how to file grievances and failed to resolve grievances	F 166	1. On February 25, 2016 Resident Council was held for all residents wishing to attend. The location of the grievance forms and who to go to if they needed help to fill them out was discussed. Also discussed was personal refrigerators and	3/10/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 03/10/2016

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F 166	Continued From page 1 regarding food storage in resident refrigerators. This was true for 10 of 18 residents in the Group Interview. This created the potential for psychosocial harm if resident concerns were not addressed. Findings included: The facility's Complaint/Grievance Investigation and Resolution policy, dated 1/15/16, documented: "All written complaints and/or grievances will be routed to the Compliance Officer or Administrator for investigation and resolution. Verbal complaints may be put in writing by a staff member and forwarded to the Compliance Officer or Administrator..." On 2/17/16 at 3:00 pm, the facility's Grievance book was reviewed and no grievances were found for the years 2015 and 2016. On 2/17/16 at 3:15 pm, during the Resident Group Interview, 10 residents said they were not aware of a location in the facility where grievance forms were available to them. They said they would report concerns to their CNA and said their concerns were not always followed up with when they reported the concerns. Several of the residents said they never received a clear explanation regarding concerns of how long food could be kept in their personal refrigerators and were told all un-consumed food was to be discarded after three days. On 2/18/16 at 10:20 am, a location for the facility's Grievance forms could not be found in the facility. On 2/18/16 at 10:00 am, CNA #2 said when	F 166	throwing away of personal food items kept in the refrigerators. 2. All residents who would like to fill out a grievance form have the potential to be affected. All residents who choose to have a personal refrigerator in their room have the potential to be affected. 3. On 2-22-16 a separate black hard plastic wall hanger was placed next to the Survey Results binder which was labeled "Grievance Forms" and the grievance forms were placed in the hanger. How to access forms and submit a grievance will be addressed at each monthly Resident Council. On 3-7-2016 and 3-8-2016 staff was inserviced on where to find the grievance forms and how to assist residents with completing them. This will be discussed in staff meeting quarterly. Specific guidelines for food and how long each type can be kept in the residents personal refrigerator will be placed on each refrigerator for resident reference. Staff will address this at each monthly Resident Council. 4. The Social Worker or her representative will provide to the monthly QA meeting a copy of the Resident Council meeting minutes that reflect the grievance process as well as the refrigerator protocol. These minutes will be reviewed by the Administrator and the QA committee.	

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F 166	Continued From page 2	F 166		

residents had a concern she could not resolve immediately, she would inform the charge nurse or the Social Worker.

On 2/18/16 at 10:05 am, CNA #3 said she would tell the charge nurse of concerns a resident had. She was not aware of any form to fill out in the resident's behalf but said she could document the concern in a CNA log book.

On 2/18/16 at 10:10 am, LN #4 said she would try to resolve concerns immediately. She said she thought there was a form to complete and was observed to walk over to an Ombudsman poster and say, "No, that's not it." She said she could not find the grievance forms and was not sure where they were located.

On 2/18/16 at 10:25 am, CNA #5 said she would tell the charge nurse of concerns a resident had. She said there were forms she could write down resident's concerns and went to the nurses station and showed the surveyor a stack of nurses notes.

On 2/18/16 at 10:30 am, LN #4 and the Social Worker were observed shuffling through papers in a black hard plastic wall hanger where the Survey Results binder was kept, in the East hallway.

On 2/18/16 at 10:35 am, LN #4 said the grievance forms were found "buried" where the Survey Results binder was kept. She took the forms and tacked them on a cork board next to the binder.

On 2/18/16 at 10:45 am, the Social Worker said

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F 166	Continued From page 3 the facility had not had a formal grievance since December of 2014. She said grievances were resolved immediately. When asked about the concern regarding resident's refrigerators and expiration dates, she said she thought that was resolved but did not have any grievance form or documentation regarding the issue. She confirmed it was problematic if staff did not know the grievance process.	F 166		
F 314 SS=D	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 services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on record review, staff and resident interview and observation, the facility failed to ensure that one of 11 sampled residents did not acquire a pressure sore. (R6). This deficient practice had the potential for harm if the resident should develop infection, or other complications . Findings included: Resident #6 was admitted to the facility 12/3/15 with diagnoses of hemiplegia following cerebral infarct affecting non dominant side and type II diabetes.	F 314	1. The diarrhea and pressure ulcer has resolved for resident #6. Her care plan has been modified to reflect her desire to sleep in the recliner. 2. All residents with a risk for pressure ulcers have the potential to be affected by the same deficient practice. 3. All residents will be assessed for pressure ulcer risk and those risk indicators will be addressed on the residents plan of care.	4/4/16

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F 314	Continued From page 4 The initial MDS assessment, dated 12/9/15, documented the resident was cognitively intact, required extensive assistance for transfers and ambulation, and the resident was at risk for pressure sores, but did not have one. A review of the clinical record for R6 revealed a care plan dated 12/22/15 for a problem of, "Risk for alteration in skin integrity related to: Requires assist for bed mobility, decreased mobility and Left hemiparesis." The interventions the facility put in place were: - Extensive assist of 1 for bed mobility, - Foam cushion in W/C, - Pressure reducing mattress in bed, - Apply special lotions/creams to maintain skin integrity, - Skin checks per facility protocol, - Monitor skin for s/s of infection, breakdown, rashes, hives, skin tears, etc. and report to the nurse, - Offer and encourage fluids, - Offer to off load and reposition every 2 hours and PRN when in bed if awake. The care plan did not document the presence of medication induced loose stools or the resident's preference to sleep in the recliner as it related to the prevention of further skin breakdown. On 1/12/16, the resident was sent to the ER for for lack of bowel movements with right sided tenderness. She was administered bowel medications and sent back to the facility a few hours later. After returning to the facility, the resident was documented to have episodes of bowel incontinence. On 1/21/16, an, "E-Z Graph Wound Assessment	F 314	4. The Wound Nurse or her representative will do a weekly QA of resident's medical records and check for new risks and compliance with addressing these risks on the care plan. This will be done weekly until 100% compliance is met for 4 weeks, then monthly until 100% is met for 3 months. Then quarterly until resolved. A QA will also be done on all new pressure areas for root cause of the pressure area. Findings of the QA checks will be reported to the administrator at the monthly QA committee meeting.	

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F 314	Continued From page 5 System" form for Resident #6 documented a Stage II preesure lever to the resident's mid inner left buttock. Length was documented as 0.7 cm, width: 0.6 cm, depth: 0.0, and wound base was red. No drainage was present. On 1/25/16,the wound was documented as 1 cm long, 0.8 cm wide and no depth.On 2/1/16, the area was documented as resolved and "scar tissue" noted at the area. The resident was interviewed on 2/17/16 at 11:00 a.m. The resident stated she preferred to sleep in the recliner and remembered the sore on her buttock. She did not know how the sore started but did remember having incontinent stools around the time it occurred. LN #1 was interviewed on 2/18/16 at 3:00 p.m., about the pressure sore. LN #1 stated the sore was caused by the resident having diarrhea which was probably from the medications she received for constipation. LN #1 stated the resident did not want to sleep in her bed, but preferred to sleep in the recliner in her room. LN #1 was asked whether there was a discussion about the effects of the diarrhea and sleeping in the recliner. She stated the staff tried to get the resident to sleep in bed but she refused.	F 314		

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	MDS001490	A. BUILDING: _____ B. WING _____	02/19/2016

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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 Arnold Rosling, RN, BSN, QIDP	C 000		
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 10 (#s 1, 3, 4, 6 & 8) sampled residents and all other residents who resided on the West hall. Findings included: On 2/16/16 at 12:50 pm, the Administrator said the windows in rooms 301 through 317 were non-operable and could not be opened. The Administrator said the facility would continue to request a waiver of the requirement.	C 492	Please renew window waiver for resident room numbers 301 - 317	3/10/16

Bureau of Facility Standards
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Electronically Signed | 03/10/16