



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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BUREAU OF FACILITY STANDARDS
3232 Elder Street
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October 21, 2016

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

Provider #: 135070

Dear Mr. Dransfield:

On **October 7, 2016**, a survey was conducted at Bear Lake Memorial Skilled Nursing Facility by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be 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. 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.) **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.

Darin Dransfield, Administrator
October 21, 2016
Page 2 of 4

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 **October 31, 2016**. Failure to submit an acceptable PoC by **October 31, 2016**, may result in the imposition of civil monetary penalties by **November 23, 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*.

We are recommending that Centers for Medicare & Medicaid Services (CMS) Region X impose the following remedy(ies):

A civil money penalty

Denial of Payment if the facility has not achieved compliance by December 14, 2016

Darin Dransfield, Administrator
October 21, 2016
Page 3 of 4

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **April 7, 2017**, 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.

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 **October 31, 2016**. If your request for informal dispute resolution is received after **October 31, 2016**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Darin Dransfield, Administrator
October 21, 2016
Page 4 of 4

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,

A handwritten signature in black ink that reads "Nina Sanderson for". The signature is written in a cursive style with a large initial "N" and a long, sweeping underline.

Nina Sanderson, LSW, Supervisor
Long Term Care

NS/pmt
Enclosures

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

PRINTED: 11/29/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135070	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/07/2016
NAME OF PROVIDER OR SUPPLIER BEAR LAKE MEMORIAL SKILLED NURSING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 164 SOUTH FIFTH STREET MONTPELIER, ID 83254		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the federal recertification survey conducted at the facility from October 3, 2016 to October 7, 2016.</p> <p>The surveyors conducting the survey were:</p> <p>Linda Kelly, RN, Team Coordinator David Scott, RN Marci Clare, RN</p> <p>ABBREVIATIONS:</p> <p>ADA = American Diabetic Association A-fib = Atrial fibrillation C/D/I = Clean/Dry/Intact CHF = Congestive heart failure CM = Centimeters DC'D = Discontinued DNS = Director of Nursing Services GCS = Glasgow coma scale (used to measure level of consciousness) LBS = Pounds LOC = Level of consciousness LPM = Liters per minute LPN = Licensed Practical Nurse MDS = Minimum Data Set MG = Milligrams MSDS = Material Safety Data Sheet(s) NC = Nasal cannula O2 = Oxygen P&P = Policy and Procedure(s) PRN = As needed PU = Pressure Ulcer O2 sat(s) = Oxygen saturation level(s) RD = Registered Dietician RN = Registered Nurse</p>	F 000			
F 279	483.20(d), 483.20(k)(1) DEVELOP	F 279		10/31/16	

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

TITLE

(X6) DATE

Electronically Signed

10/27/2016

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

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F 279 SS=D	<p>Continued From page 1 COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</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 comprehensive care plans addressed implanted devices. This was true for 1 of 10 sample residents (#2). The failed practice created the potential for harm if Resident #2's needs were unmet due to lack of direction in the care plan about his/her pacemaker. Findings include:</p> <p>Resident #2 was admitted to the facility in 2014 with multiple diagnoses, including A-fib, CHF and hypertension.</p>	F 279	<p>The care plan for resident #2 was revised and updated on 10-5-16 with pacemaker problem goal and interventions added.</p> <p>Residents who have a pacemaker could be affected if pacemaker is not care planned. Care plans for other residents who have a pacemaker were revised and revisions made as appropriate.</p> <p>A checklist of items to be considered in the initial care planning process was</p>		

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F 279	Continued From page 2 On 10/4/16 at 9:50 am, Resident #2 said s/he thought his/her pacemaker may have malfunctioned at one point and caused a fall. However, the resident said the pacemaker checked out "okay" and it was not the problem. Resident #2's current care plan did not include the pacemaker. On 10/5/16 at 2:45 pm, after reviewing Resident #2's clinical record, the DNS said she did not find a care plan for the pacemaker. The DNS said the pacemaker should have been included in the care plan to address scheduled pacemaker checks and what staff are to do if the pacemaker malfunctions.	F 279	developed to ensure that residents who have a pacemaker have a care plan to direct staff in their care. Care plans will be reviewed at quarterly care plan meetings to ensure all needs of residents are addressed in their care plan. To monitor performance, care plan review audits will be conducted by the DNS or other Licensed nurse weekly x4 weeks, then monthly, then quarterly		
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, record review, and policy review, it was determined the facility failed to ensure licensed nursing staff adhered to professional standards of practice. This was true for 3 of 5 sample residents (#2, #4 & #10) reviewed for falls. The failure to meet professional standards of practice created the potential for more than minimal harm if: a) there was a delay in recognizing and reporting a deterioration in the neurological status of Resident #2, #4 & #10 who experienced an accident in which there was head injury or the	F 281	Corrective actions for residents #2 and #4 include: Any future unwitnessed falls or head injuries will have Neurological Checks per facility protocol. Resident #10 is deceased. Any resident who has an unwitnessed fall or sustains a head injury has the potential for negative outcomes if neuro-checks are not assessed. The policy for assessing Neuro checks	10/31/16	

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F 281	<p>Continued From page 3 potential for head injury. Findings include:</p> <p>According to Lippincott Manual of Nursing Practice, ninth edition, by Wolters Kluwer Health, Lippincott, Williams & Wilkins, 2010, "Head injuries can include fractures to the skull and face...and indirect injuries to the brain (such as a concussion, contusion, or intracranial hemorrhage). Head injuries commonly occur from...falls..." Primary assessment included the patient's neurologic status. Subsequent assessment included a history of the event, LOC "a. Change in the LOC is the most sensitive indicator of a change in the patient's condition. b. GCS...", vital signs, unequal or unresponsive pupils, confusion or personality changes, impaired vision, one or both eyes appear sunken, seizure activity, a bluish discoloration behind the ears (indicates a possible basal skull fracture), rhinorrhea or otorrhea (discharge from the nose or ear indicative of leakage of cerebrospinal fluid) and periorbital ecchymosis (dark rings around the eyes indicative of anterior basilar fracture).</p> <p>On 10/5/16 at 3:10 pm, the DNS provided an undated Accident and Incident Investigation document which she said was the facility's P&P regarding falls. This P&P documented, "Purpose: 1. To investigate the cause of all marks, discolorations, skin breaks, and injuries to residents... 2. To identify any injuries after a resident sustains an accident or incident. 3. To determine the root cause...and prevent future accidents..." General Guidelines included, "Assess any change in mental and cognitive status." The Investigative Procedure included, "Observe and assess neurological status. If the resident has sustained a head injury,</p>	F 281	<p>has been updated and reviewed with Licensed Nursing staff at an inservice on 10-25-16. The Facilities Fall Log has been revised to include whether the fall was witnessed or unwitnessed and whether Neuro checks were performed.</p> <p>Audits will be completed by the Administrator, DNS or other QA committee member(s) weekly</p>		

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F 281	<p>Continued From page 4</p> <p>neurological status must be assessed every two hours for the first twelve hours and then every four hours for the next twelve hours and then every eight hours for the next 48 hours (72 hours total). Neuro checks must be documented...and placed in the resident's chart."</p> <p>1. Resident #2 was admitted to the facility in 2014 with multiple diagnoses, including A-fib, CHF and hypertension.</p> <p>Resident #2's 7/3/16 quarterly MDS assessment documented intact cognition and no falls. The 9/25/16 annual MDS assessment also documented intact cognition; however, it also documented 2 falls, 1 non-injury and 1 with injury, but not major injury.</p> <p>Incident/Accident Reports documented Resident #2 fell on 8/6/16, 9/10/16 and 10/1/16.</p> <p>The 8/6/16 fall was witnessed and staff assisted Resident #2 to the floor. S/he was not injured.</p> <p>The 9/10/16 fall occurred at 4:50 am. The fall was not witnessed. Resident #2 was found on the floor by the toilet in his/her bathroom. A 9/12/16 Falls Team Meeting summary documented the resident said "my arms and legs gave away and I blacked out...I must not have been completely out because I caught myself..."</p> <p>The 10/1/16 fall occurred at 12:30 am. The fall was not witnessed. Resident #2 was found on his/her back in the bathroom. On 10/3/16, the DNS assessed the resident and documented, "States [s/he] reached for a disposable wash cloth et [and] as [s/he] leaned, 'blacked out' et</p>	F 281			

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F 281	<p>Continued From page 5 [and] fell backward against the towel rack and down the wall to the floor."</p> <p>There was no documented evidence in the EMR or paper clinical record that Resident #2's neurological status was assessed after the 9/10/16 and 10/1/16 falls in which the resident said s/he "blacked out."</p> <p>On 10/4/16 at 9:50 am, Resident #2 said s/he had three falls in the last few months and "blacked out" during two of the falls.</p> <p>On 10/5/16 at 2:45 pm, the DNS said Resident #2's neurological status was not assessed after the 9/10/16 and 10/1/16 falls because the resident was able to say what happened both times. When asked how the facility knew the resident did not hit his/her head during those falls, the DNS said they did not know.</p> <p>2. Resident #4 was admitted to the facility in January 2016 with multiple diagnoses including anxiety disorder, pain, and general muscle weakness.</p> <p>Resident #4's 1/25/16 admission MDS assessment documented a history of falls and the 7/17/16 quarterly MDS assessment documented 1 non-injury fall and 1 fall with injury, but not major injury.</p> <p>Incident/Accident Reports documented Resident #4 fell twice on 5/27/16. The first fall occurred at 11:45 am while the resident ambulated to the dining room. Staff and visitors witnessed the resident's fall to the floor which resulted in a hematoma to back of the head. The second fall,</p>	F 281			

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F 281	<p>Continued From page 6 which occurred around 6:30 pm, was not witnessed. Staff heard a yell for "help" then found the resident on the floor "leaned up against the toilet" in his/her bathroom.</p> <p>There was no documented evidence in the EMR or the paper clinical record that Resident #4's neurological status was assessed after either fall on 5/27/16.</p> <p>On 10/5/16 at 4:55 pm, the DNS said the facility's policy was that staff check the neurological status of a resident who sustained a head injury from a fall. The DNS said she did not find neurological checks related to either of Resident #4's falls on 5/27/16.</p> <p>3. Resident #10 was admitted to the facility on 8/24/16 with multiple diagnoses including hypovolemic shock, myocardial infarct [heart attack], seizure disorder, depression, coronary artery disease, and brain meningioma [tumor] resection.</p> <p>Resident #10's 8/31/16 admission MDS assessment documented no history of falls.</p> <p>Incident/Accident Reports documented Resident #10 had a fall on 9/14/16 that occurred at 11:20 pm when Resident #10 was attempting to toilet independantly. Staff found Resident #10 face down on the floor with a laceration on the left eyebrow, and abrasions with bruising on both knees.</p> <p>There was no documented evidence in the EMR or the paper clinical record that the facility assessed Resident #10's neurological status</p>	F 281			

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F 281	Continued From page 7 after the fall on 9/14/16.	F 281			
F 314 SS=G	<p>On 10/5/16 at 4:55 pm, the DNS said the facility's policy required staff to check the neurological status of a resident who sustained a head injury resulting from a fall. The DNS said she did not find neurological checks related to Resident #10's fall on 9/14/16.</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to prevent the development of avoidable pressure ulcers, recurring Stage II pressure ulcers, and multiple Stage III pressure ulcers. This was true for 1 of 1 sampled resident (#1) reviewed for pressure ulcers and resulted in harm to Resident #1 when she developed multiple and recurrent Stage II and Stage III pressure ulcers. Findings include:</p> <p>1. Resident #1 was admitted to the facility on 8/9/11 with multiple diagnoses, including care for an infected surgical wound, diabetes mellitus, dementia, and morbid obesity.</p>	F 314	<p>All pressure ulcers for resident #2 have healed. A Braden assessment was completed on 10-10-16, placing her at moderate risk for the development of Pressure ulcers. Her care plan has been revised to reflect current interventions for the prevention of further pressure ulcers.</p> <p>Residents whose Braden score is <15 are considered to be at risk for the development of pressure ulcers. Care plans for all residents whose Braden score is <15 were reviewed and revisions made as appropriate.</p>	10/31/16	

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F 314	<p>Continued From page 8</p> <p>Resident #1 developed a Stage II pressure ulcer to her gluteal fold on 6/13/15; multiple Stage III pressure ulcers to her coccyx and sacrum beginning on 2/3/16; and recurrent pressure ulcers to the coccyx area beginning 5/29/16, as follows:</p> <p>a. Resident #1's Annual MDS assessment, dated 3/3/15, documented the following:</p> <ul style="list-style-type: none"> * No pressure ulcers present on the prior assessment * At risk of developing pressure ulcers * Extensive assistance of 2 staff required for bed mobility * Total dependence on staff for transfers * Total dependence on 1 staff for locomotion in a wheelchair <p>Resident #1's pressure ulcer care plan, dated 3/4/15, directed staff to:</p> <ul style="list-style-type: none"> * Inspect the resident's skin during bathing and other personal care * Apply topical treatments per physician order <p>Resident #1's clinical record did not contain physician orders for topical treatments, and the facility was unable to provide physician orders related to topical treatments in effect prior to 2/1/16. Both care plan interventions were discontinued on 9/22/15.</p> <p>A 4/26/15 physician's order documented Resident #1 was to receive Petrolatum ointment, as needed, four times daily. No other physician or nursing orders related to preventative skin</p>	F 314	<p>Treatment orders will be entered in the residents chart in Point Click Care to enable Licensed Nurses to document treatments. Treatment documentation will link to the order to minimize confusion related to dressing changes and other treatments ordered by the physician. All staff members received training on prevention of pressure sores at an inservice on 10-13-16. All Licensed staff received additional training on prevention, treatment and documentation of pressure sores at an inservice on 10-25-16.</p> <p>The DNS or other Licensed nurse will audit treatment orders/documentation daily for two weeks then weekly for 4 weeks then monthly for three months then quarterly thereafter.</p> <p>Audits for residents at risk for the development of pressure sores will be conducted by the DNS or other Licensed Nurse to assess the appropriateness of bed and support surfaces, nutrition (dietary intake, snacks, supplements, etc.), mobility and moisture (incontinence) weekly for 4 weeks then monthly for 3 months then quarterly</p>		

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F 314	<p>Continued From page 9</p> <p>care were found in Resident #1's record May 2015 through August 2015. When requested, none were provided by the facility.</p> <p>Resident #1's skin care plan, initiated on 6/13/15, when a Stage II pressure ulcer was discovered on the center gluteal fold, directed staff to apply Vaseline to Resident #1's buttocks after each toileting or episode of incontinence, assist with repositioning every 30 minutes during the day and every two hours throughout the night, utilize foam wedges when repositioning, and inspect the resident's skin with each repositioning.</p> <p>Physician Visit Notes, dated 6/4/15 and 6/7/15, addressed alterations in Resident #1's mental status, dehydration concerns, and renal insufficiency. The notes did not include documentation related to Resident #1's skin.</p> <p>A Nursing Note, dated 6/10/15, documented Resident #1 had experienced an 11.1% weight loss.</p> <p>On 6/13/15, a Wound-Weekly Observation Tool documented Resident #1 had a "facility acquired" Stage II pressure ulcer measuring 2.5 cm x 0.5 cm x 0.2 cm, and described it as a "healing, moist wound, with scant amount of serosanguinous drainage." The Observation Tool documented, "We looked into a bariatric overlay for bed but Purchasing reported it was too costly and mattress she has is sufficient for needs."</p> <p>A 6/14/15 Nursing Note for Resident #1 documented, "Open area noted on center gluteal fold measuring 2.5 cm x 1 cm. Slight bleeding noted coming from area. Also open area noted</p>	F 314			

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F 314	<p>Continued From page 10 on left buttock measuring 0.5 cm x 0.5 cm..."</p> <p>A 6/23/15 Wound-Weekly Observation Tool documented the Stage II pressure ulcer now measured 2.5 cm x 0.77 cm x 0.2 cm. The Weekly Observation Tool documented there were "no changes made to treatment plan, current plan is working, Purchasing unable to get overlay mattress for bed..."</p> <p>On 10/6/16 at 8:45 am, RN #1 stated "We had a different bed for her after her significant weight loss and her first pressure ulcer in July of 2015. At the time, I would have liked a better bed, but it wasn't feasible. When she was on the bariatric bed I would have liked to have had her on the specialty bed as I was concerned with her Braden [pressure ulcer risk assessment score]. I repositioned her every 30 minutes because of her being on the regular bed and she started to have an overall decline." RN #1 also stated the "pressure reducing mattress" Resident #1 used at that time "was the same" as those provided to other residents in the facility that were not at risk for pressure ulcers. RN #1 stated, "If the pressure ulcer is on the bottom [sacrum, coccyx, gluteal folds], I usually recommend Auqaphor [topical agent], because if a resident is having lots of bowel movements we are constantly taking off the dressing, causing more harm."</p> <p>Resident #1 was not provided with a bed sufficient to meet her skin care needs.</p> <p>Wound-Weekly Observation Tools documented the following:</p> <p>* 6/30/15 - Stage II pressure ulcer to center</p>	F 314			

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F 314	<p>Continued From page 11</p> <p>gluteal fold measuring 2.2 cm x 0.7 cm x 0.2 cm. No changes made to Resident #1's treatment plan this week.</p> <ul style="list-style-type: none"> * 7/7/15 - Stage II pressure ulcer to center gluteal fold measuring 2.0 cm x 0.6 cm x 0.2 cm. * 7/14/15 - Stage II pressure ulcer to gluteal fold measuring 2.0 cm x 1.6 cm x 0.2 cm. * 7/21/15 - Stage II pressure ulcer to gluteal fold measuring 1.5 cm x 0.3 cm x 0.2 cm. * 7/29/15 - Stage II pressure ulcer to gluteal fold measuring 1.5 c m x 0.4 cm x 0.2 cm. * 8/7/15 - Stage II pressure ulcer to gluteal fold measuring 1.5 cm x 0.3 cm x 0.2 cm. <p>No other Wound-Weekly Observation Tools related to the gluteal fold pressure ulcer were found in Resident #1's record.</p> <p>On 10/6/16 at 8:25 am, the DNS stated there should have been physician orders for Auqaphor and the dressing changes, but there were not. The DNS said a Weekly Wound sheet was to be done for a resident who has a wound and should be done weekly until the wound is resolved. The DNS further said the Skin Observation sheet is to be done weekly.</p> <p>b. Resident #1's Annual MDS assessment, dated 2/2/16, documented the following:</p> <ul style="list-style-type: none"> * No pressure ulcers present or at time of prior assessment * Severely impaired cognitive skills * Extensive assistance of 2 staff required for transfers, bed mobility, and ambulation * Significant weight loss, not on physician-prescribed weight-loss regimen * At risk of developing pressure ulcers 	F 314			

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F 314	<p>Continued From page 12</p> <p>* Pressure reducing devices for chair, bed, and turning/repositioning programs</p> <p>Braden Scale assessments, dated 11/4/15 and 1/30/16, each documented Resident #1 was at "high risk" of developing pressure ulcers.</p> <p>The facility's Skin Assessment Guidelines documented residents at "high risk" for pressure ulcers would receive weekly skin checks performed by the facility's skin care team.</p> <p>A 1/27/16 Nurses' Note documented, "Dressing to coccyx was changed..."</p> <p>A 2/3/16 Nurses' Note documented, "Dressing C/D/I to coccyx..."</p> <p>A Weekly Skin Observation Tool and Skin/Wound care plan for 11/4/15 through 1/29/16, were not found in Resident #1's record and were not provided by the facility when requested.</p> <p>A Skin Observation Sheet, dated 2/3/16, documented Resident #1 had developed two Stage III pressure ulcers "right over the coccyx [#1] and one just to the left of it [#2]." Pressure Ulcer #1 measured 2.3 cm x 0.3 cm x 0.2 cm; Pressure Ulcer #2 measured 4.4 cm x 1.4 cm x 0.2 cm."</p> <p>A Wound-Weekly Observation Tool, dated 2/4/16, documented Resident #1 developed a "facility acquired" Stage III pressure ulcer to the coccyx, and a second Stage III pressure ulcer to the left of the coccyx. Pressure Ulcer #1 was described as moist with a moderate amount of serosanguinous drainage and measuring 4.4 cm</p>	F 314			

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F 314	<p>Continued From page 13</p> <p>x 1.4 cm x 0.2 cm. The treatment plans included, "Bed will be moved out and patient will be placed on an air floatation mattress..." Pressure Ulcer #2 was described as moist with a moderate amount of serosanguinous drainage, and measured 2.3 cm x 0.3 cm x 0.2 cm.</p> <p>A 2/4/16 physician visit note documented, "RN here to eval[uate] coccyx ulcer ... coccyx has grade 3 [Stage III] ulcer..."</p> <p>A Skin Observation Sheet, dated 2/9/16, documented Pressure Ulcer #1 was healing and measured 3 cm x 0.8 cm x 0.2 cm. Pressure Ulcer #2 was described as "healed."</p> <p>A Weekly-Wound Observation Tool, dated 2/9/16, documented Pressure Ulcer #1 measured 3.0 cm x 0.8 cm x 0.2 cm. The Tool documented, "[Resident #1] placed on air flotation mattress. We will continue with current treatment plan as it is working and will reassess next week, daily dressing changes done and daily charting per licensed staff." The next Weekly Wound Observation Tool in Resident #1's clinical record was dated 3/15/16, 34 days later.</p> <p>Nurses' Notes documented the dressing to the coccyx wound was changed daily from 2/10/16 through 2/13/16.</p> <p>A Skin Observation Sheet, dated 2/16/16, documented Resident #1's Stage III pressure ulcer now measured 1.3 cm x 0.8 cm x 0.1 cm.</p> <p>A Skin Observation Sheet, dated 3/2/16, documented the coccyx wound measured 0.8 cm x 0.5 cm x 0.1 cm. Notes documented staff</p>	F 314			

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F 314	<p>Continued From page 14</p> <p>applied Normagel with Mepilex to the wound on 3/2/16 and 3/8/16, at which time the coccyx ulcer measured 0.7 cm x 0.5 cm x 0.1 cm.</p> <p>A Weekly-Wound Observation Tool, dated 3/15/16, documented the Stage III sacral wound now measured 0.6 cm x 0.3 cm x 0.1 cm and that staff would "continue to monitor weekly and continue with current dressing changes."</p> <p>A Weekly-Wound Observation Tool, dated 3/28/16, stated, "PU has healed, Mepilex with border to sacrum has been dc'd. Will continue to monitor..."</p> <p>Resident #1's clinical record did not contain physician orders related to wound dressings or how frequently dressing changes should have been performed. Staff performed dressing changes for Resident #1, without physician orders, on:</p> <ul style="list-style-type: none"> * 2/14/16-2/16/16 * 2/18/16-2/20/16 * 2/28/16 * 3/3/16-3/8/16 * 3/10/16 * 3/13/16-3/16/16 * 3/19/16-3/22/16 * 3/24/16-3/28/16. <p>c. A 4/19/16 Braden Scale assessment documented Resident #1 was at "high risk" for the development of pressure ulcers. The Facility Skin Assessment Guidelines documented residents at "high risk" for pressure ulcers would receive weekly skin checks performed by the facility's skin care team.</p>	F 314			

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F 314	Continued From page 15 The next Skin Observation Tool for Resident #1, dated 5/29/16, documented a new Stage II pressure ulcer had been identified on her coccyx and measured 1.5 cm x 0.3 cm x 0.1 cm. Residents #1's Nurses' Notes documented the following: * 5/29/16 - 8:31 pm: "Stage II PU noted to coccyx where previous PU has been..." * 5/31/16 - 10:07 am: "Mattress to bed changed to auto-repo[sition] mattress [sic]." * 6/1/16 - 4:37 pm: "Stage II PU to coccyx healing well..." * 6/6/16 - 10:35 am: "Stage II PU to coccyx has healed..." Resident #1's clinical record did not contain Weekly-Wound Observation Tools from 4/1/16 through 6/6/16 and no Skin Observation Sheets for the period of time after 6/6/16, were provided by the facility. On 10/7/16 at 8:45 am, the DNS provided physician wound care orders, dated 2/1/16 and 3/2/16, and stated no others were found. The facility failed to ensure Resident #1 did not develop avoidable and recurrent Stage II pressure ulcers, or prevent the development of avoidable multiple Stage III pressure ulcers.	F 314			
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives	F 323		10/31/16	

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F 323	<p>Continued From page 16</p> <p>adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and MSDS review, it was determined the facility failed to ensure harmful chemicals were securely stored in 1 of 2 tub rooms (North). The failure created the potential for harm for 1 of 10 sample residents (#7) and for any other independently mobile, cognitively impaired residents who could access the unsecured chemicals. Findings include:</p> <p>On 10/6/16 at 10:50 am, during a tour of the facility environment with Maintenance Staff #1, seven containers of six different hazardous chemicals were found in an unlocked closet in the North Tub Room. No other staff were in the room at the time.</p> <p>The unsecured chemicals and their respective MSDS hazardous identifications or warnings were:</p> <ul style="list-style-type: none"> * 1 spray bottle of natural citrus cleaner/degreaser - "Corrosive to skin and eyes on contact..." * 1 spray bottle of foaming shower/restroom cleaner - "Corrosive to skin and eyes on contact..." * 2 spray bottles of Professional Lysol 	F 323	<p>Closet doors that contain chemicals will remain locked at all times when a staff member is not in the room. Bath aides received instruction in resident safety and the need to keep chemicals locked at an in-service on 10-26-16</p> <p>Any resident who is cognitively impaired and independently mobile who could access unsecured chemicals has the potential to be affected.</p> <p>Random audits will be conducted throughout the day, particularly during bath times, to assure closets containing chemicals are locked</p> <p>Audits will be completed daily for one week then weekly for 4 weeks then monthly thereafter</p>		

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F 323	Continued From page 17 Disinfectant Basin Tub & Tile Cleaner - "Hazards to humans...Causes eye irritation. Do not get in eyes or on clothing..." * 1 gallon container of hospital grade disinfectant - "Causes serious eye irritation. Causes skin irritation." * 1 gallon container of Clorox Bleach - "Danger: Corrosive. May cause severe irritation or damage to eyes and skin. Vapor or mist may irritate. Harmful if swallowed..." * 1 gallon container of Hibiclens - "Avoid contact with eyes." A sign on the outside of the unlocked closet instructed, "Please make sure the closet is closed and locked if you leave the room! No exceptions!" And, the key to the closet was hung on one of closet door pulls.	F 323			
F 325 SS=G	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced	F 325		10/31/16	

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F 325	<p>Continued From page 18</p> <p>by:</p> <p>Based on record review and staff interview, it was determined the facility failed to ensure residents were provided with adequate nutritional support to avoid severe weight loss. This was true for 1 of 2 residents (#1) sampled for weight loss and resulted in harm when Resident #1 lost 23-pounds in 20 days, 14.5 pounds in 28 days, and a total of 109.5 pounds, or 37.1% of her body weight, in six months. Findings include:</p> <p>Resident #1 was admitted to the facility on 8/19/11 with multiple diagnoses, including care of an infected wound, hyponatremia, diabetes, dementia, GERD, morbid obesity, and depression.</p> <p>Resident #1's Annual MDS assessment, dated 3/3/15, documented the following:</p> <ul style="list-style-type: none"> * Intact cognition * No dental issues * No swallowing disorder * No weight loss * Weight = 288 pounds, height =5-foot, 2 inches * Set-up assistance only required by staff for eating <p>Resident #1's nutritional care plan, dated 3/4/15, documented staff were to "promote healthy food choices, but recognize [Resident #1's] right to have foods of her choosing." No additional nutritional care plans, in effect for 3/4/15 to 7/8/15, were contained in Resident #1's clinical record.</p> <p>Resident #1's Weights and Vitals Summary documented the following weights:</p>	F 325	<p>Resident #1 was ordered appetite stimulant on 8-5-16 for anorexia and weight loss. She gained 14 lbs in 30 days. The dose was decreased d/t rapid weight gain on 9-15-16. She has continued to have weight gain at the current dose. Her weight is monitored weekly.</p> <p>Any resident who has a weight loss >5% in 30 days has the potential to be affected. (Weight loss alerts are generated by the Point Click Care system). Care plans for other residents for whom an alert was generated for weight loss were reviewed and revisions made as appropriate.</p> <p>The policies for Tracking Weight Changes and Significant Weight Loss have been revised and updated. All Bath aides and Licensed Nurses were required to review the policies and sign acknowledgment and understanding of the policy. The DNS and Dietitian will meet weekly to review resident weights and nutritional concerns. Concerns will be discussed with Nursing staff and care plan interventions initiated, as appropriate.</p> <p>The dietitian will be notified of all alerts, as well as any resident who has been identified to be at risk for the development of pressure sores. She will attend weekly skin meetings to address any nutritional concerns, as well.</p> <p>Alerts and weights for residents who are at risk for significant weight loss will be</p>		

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F 325	<p>Continued From page 19</p> <p>* 3/26/15 = 295.5 pounds * 4/16/15 = 296.5 pounds * 5/7/15 = 294 pounds * 6/4/15 = 261.5 pounds [An 11% loss of body weight, in 28 days.]</p> <p>Resident #1's Nutritional Review, dated 6/4/15, documented a 1500-calorie ADA diet with average food intake less than 75%, average fluid intake at 75%, independent with eating, weight of 294 pounds, and that Resident #1's weight would be "reviewed weekly."</p> <p>A Weight Change Note for Resident #1, dated 6/10/15, documented, "Weight warning: 11.1% (32.5 lbs) weight loss in last 1 month, 11.5% (34 lbs) in last 3 months ... [Resident #1] has been more depressed and asleep during the day and meals are often refused ... "</p> <p>A Weights and Vitals Summary documented Resident #1 weighed 267 pounds on 6/11/15.</p> <p>A Weight Change Note for Resident #1, dated 6/15/15, recorded her weight at 258 pounds and documented, "Weight warning: 9.6% (28.5 lbs) weight loss in last 3 months ... significant weight loss this past month ... weight loss would be beneficial, but goal was for gradual weight loss to occur ... allow gradual weight loss of 2-4 pounds per month."</p> <p>A Weights and Vitals Summary documented Resident #1 weighed 258 pounds on 6/18/15.</p> <p>A Nutrition/Dietary Note, dated 6/24/15, recorded Resident #1's weight as 247.5 pounds and</p>	F 325	<p>monitored weekly for 4 weeks then monthly for 3 months then quarterly by the DNS or other Licensed Nurse.</p>		

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F 325	<p>Continued From page 20 documented, "Will continue with goal for gradual weight loss..."</p> <p>A Weights and Vitals Summary documented Resident #1 weighed 247.5 pounds on 7/2/15.</p> <p>A Weight Change Note for Resident #1, dated 7/14/15, documented, "Weight warning: 5.4% (14 lbs) weight loss in last month, 16.5% (49 lbs) weight loss in last 3 months, 13.2% (37.5 lbs) in last 6 months..."</p> <p>A Nutrition/Dietary Note, dated 7/20/15, documented Resident #1 was "on comfort measures...She needs softer foods as she does not chew well..."</p> <p>A Nutritional Review, dated 8/26/15, documented Resident #1 received a mechanical soft diet, her average food intake was less than 75%, her fluid intake was 75%, she was independent with eating, her weight was not documented, and she remained on "comfort measures."</p> <p>A Nutritional Review, dated 11/18/15, documented Resident #1 received an ADA diet, average food intake was 50%, average fluid intake was 50%, she was independent with eating, a current weight was not provided, and she remained on "comfort measures."</p> <p>An undated nutritional care plan, printed on 11/23/15, documented, "[Resident #1] is on comfort measures... Encourage monthly weights..."</p> <p>A Weights and Vitals Summary documented the following weights for Resident #1:</p>	F 325			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135070	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/07/2016
NAME OF PROVIDER OR SUPPLIER BEAR LAKE MEMORIAL SKILLED NURSING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 164 SOUTH FIFTH STREET MONTPELIER, ID 83254		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 325	<p>Continued From page 21</p> <ul style="list-style-type: none"> * 12/3/15 = 281 pounds * 12/10/15 = 284 pounds * 12/17/15 = 269 pounds * 12/24/15 = 254 pounds * 1/7/16 = 249 pounds <p>Resident #1's nutritional care plan, dated 1/7/16, documented, "Recent weight loss related to poor oral intake... Resident on comfort measures," Comfort measures for Resident #1 were discontinued on 2/10/16.</p> <p>A Weight Change Note for Resident #1, dated 1/11/16, documented, "Weight warning...Will order Arginaid or Jeven supplements..."</p> <p>Weights and Vitals Summary documented the following for Resident #1:</p> <ul style="list-style-type: none"> * 1/21/16 = 228.5 pounds * 1/28/16 = 221.5 pounds * 2/4/16 = 216.5 pounds <p>Resident #1's Weight Change Note, dated 2/10/16, documented, "Weight warning...13.1% (32.5 lbs) weight loss in last month, 26.6% (78.5 lbs) weight loss in last 3 months, 22.8% [weight loss] (64 lbs) in last 6 months..."</p> <p>A Nutritional Assessment Form, dated 2/12/16, documented Resident #1 had experienced a weight change of 13% in 30 days. Interventions included, "Patient has been on comfort measures... continue to review weights..."</p> <p>Resident #1's clinical record did not contain additional Nutritional Assessment forms, but</p>	F 325			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135070	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/07/2016
NAME OF PROVIDER OR SUPPLIER BEAR LAKE MEMORIAL SKILLED NURSING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 164 SOUTH FIFTH STREET MONTPELIER, ID 83254		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 325	<p>Continued From page 22</p> <p>Weights and Vitals summaries documented the following:</p> <ul style="list-style-type: none"> * 2/18/16 = 225.5 pounds * 2/25/16 = 206.5 pounds * 3/10/16 = 203.5 pounds <p>A Weight Change Note for Resident #1, dated 3/14/16, documented, "Weight warning...significant weight loss of 5.8% over last 1 month, 24.3% last 3 months, 31% last 6 months."</p> <p>A Weights and Vitals Summary documented Resident #1 weighed 202 pounds on 3/17/16 and noted, "31.5% (93 lbs) weight loss since 11/18/15... 20.5% (52 lbs) weight loss since 12/24/15..."</p> <p>Weights and Vitals summaries for Resident #1 documented the following:</p> <ul style="list-style-type: none"> * 3/24/16 = 195 pounds * 3/31/16 = 198 pounds * 4/7/16 = 198 pounds * 4/14/16 = 187.5 pounds * 4/21/16 = 187 pounds <p>A Weights and Vitals Summary for Resident #1, dated 4/21/16, documented, "36.6% (108 lbs) weight loss since 11/18/15...15.6% (34.5 lbs) weight loss since 1/28/16..."</p> <p>A Weights and Vitals Summary for Resident #1, dated 4/25/16, documented a weight of 185 pounds and noted, "37.3% (110 lbs) weight loss since 11/18/15...16.5% (36.5 lbs) weight loss since 1/28/16..."</p>	F 325			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135070	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/07/2016
NAME OF PROVIDER OR SUPPLIER BEAR LAKE MEMORIAL SKILLED NURSING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 164 SOUTH FIFTH STREET MONTPELIER, ID 83254		
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F 325	<p>Continued From page 23</p> <p>A Quarterly MDS Assessment, dated 4/26/16, documented Resident #1 was "feeling down," had little interest in doing things, felt tired, had little energy, required limited assistance of 1 staff for eating, experienced no issues with swallowing, did not receive antidepressant medications, and weighed 187 pounds.</p> <p>A 4/28/16 Weights and Vitals Summary, dated 4/28/16, documented Resident #1 weighed 183.5 pounds, which represented a "37.8% (111.5 lbs) weight loss since 11/18/15...15.2% (33 lbs) weight loss since 2/4/16..."</p> <p>A Weights and Vitals Summary, dated 5/5/16, documented Resident #1 weighed 185.5 pounds and noted, "37.1% (109.5 lbs) weight loss since 11/18/15...14.1% (30.5 lbs)weight loss since 2/11/16..."</p> <p>Weights and Vitals summaries documented Resident #1 weighed 186 pounds on 5/12/16 and 182 pounds on 5/19/16.</p> <p>Resident #1's Nutritional Review, dated 5/20/16, documented a weight of 186 pounds, she continued to receive an ADA diet, average food intake was 25-50%, average fluid intake of 50%, she now required assistance to eat. The nutritional care plan documented, "No changes needed, she is still comfort cares..."</p> <p>Weights and Vitals Summaries for Resident #1 documented the following:</p> <ul style="list-style-type: none"> * 5/26/16 = 186.5 pounds * 6/2/16 = 184 pounds 	F 325			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135070	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/07/2016
NAME OF PROVIDER OR SUPPLIER BEAR LAKE MEMORIAL SKILLED NURSING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 164 SOUTH FIFTH STREET MONTPELIER, ID 83254		
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F 325	<p>Continued From page 24</p> <ul style="list-style-type: none"> * 6/9/16 = 182 pounds * 6/16/16 = 181 pounds * 6/23/16 = 178 pounds * 6/30/16 = 176.5 pounds <p>A physician order, dated 7/1/16, documented staff were to administer Megestrol to Resident #1 for a diagnoses of anorexia each morning. The order was discontinued on 7/2/16 and a new order, also dated 7/2/16, directed staff to provide Megestrol suspension to Resident #1 daily.</p> <p>A Weight Change Note for Resident #1, dated 7/5/16, documented, "Weight Warning...she continues to decline, she refuses meals, and help with meals often. Failure to thrive due to desire to give up on living."</p> <p>Weights and Vitals summaries documented Resident #1 weighed 175.5 pounds on 7/7/16 and 178 pounds on 7/14/16. A physician order, dated 7/16/16, discontinued the use of Megestrol for anorexia.</p> <p>A Weights and Vitals Summary documented Resident #1 weighed 171 pounds on 7/21/16.</p> <p>Resident #1's Nutritional Review, dated 7/27/16, documented a weight of 171 pounds, ADA diet, average food intake of 25%, and an average fluid intake of 50%. The review documented Resident #1 "continues to have weight loss..."</p> <p>Weights and Vitals summaries documented Resident #1 weighed 164 pounds on 7/28/16 and 162.5 pounds on 8/4/16.</p> <p>A physician order, dated 8/4/16, documented</p>	F 325			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135070	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/07/2016
NAME OF PROVIDER OR SUPPLIER BEAR LAKE MEMORIAL SKILLED NURSING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 164 SOUTH FIFTH STREET MONTPELIER, ID 83254		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 325	<p>Continued From page 25</p> <p>staff were to provide Resident #1 with Cyproheptadine 4 mg, for diagnoses of anorexia and weight loss.</p> <p>Weights and Vitals summaries for Resident #1 documented the following:</p> <ul style="list-style-type: none"> * 8/11/16 = 158.5 pounds * 8/18/16 = 164 pounds * 8/25/16 = 171.5 pounds * 9/1/16 = 171 pounds * 9/8/16 = 171 pounds * 9/15/16 = 178 pounds * 9/22/16 = 181 pounds * 9/29/16 = 186 pounds <p>On 10/5/16 at 11:00 am, when asked to provide documentation of efforts the facility made to curb Resident #1's severe weight loss from April 2015 through July 2016, the facility's RD stated Resident #1's family did not want the facility to "make" her eat while "depressed" over the loss of a deceased child and, more recently, the death of a spouse. The RD noted Resident #1 desired to lose some weight and had been placed on "comfort measures" from 1/21/16 through 2/11/16. When asked to provide evidence of the facility's efforts to address the severe rate of weight loss experienced by Resident #1, the RD stated, "I have all my records at home; I don't have an office here anymore. I wasn't concerned about the rate of weight loss as Resident #1 wanted to lose weight." When asked about regular scheduled meetings with the Interdisciplinary Team to discuss weight loss and pressure ulcer prevention, the RD stated, "I'm not really part of the skin treatment team. I'm not notified usually of pressure ulcers except at</p>	F 325			

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NAME OF PROVIDER OR SUPPLIER BEAR LAKE MEMORIAL SKILLED NURSING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 164 SOUTH FIFTH STREET MONTPELIER, ID 83254		
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F 325	Continued From page 26 Monthly CQI and family conferences."	F 325			
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; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview and record review, it was determined the facility failed to ensure O2 was administered according to physician orders and consistently monitored for efficacy. This was true for 2 of 6 sample residents (#1 and #2) reviewed for specialty care and services. The failure placed both residents at risk for suboptimal benefit from the oxygen and at increased risks for side effects or complications. Findings include: 1. Resident #2 was admitted to the facility in 2014 with multiple diagnoses, including CHF. Resident #2's annual MDS assessment, dated 9/25/16, documented intact cognition and O2 use. Resident #2's care plan interventions for CHF	F 328	O2 sats have been monitored and documented consistently for resident #1. Resident #2's oxygen order was reviewed and verified. O2 settings have been monitored randomly and O2 has been observed to be at correct setting. O2 sats have remained within acceptable range for the resident. Any resident who requires supplemental oxygen has the potential to be affected The use of oxygen, importance of assuring O2 is set at prescribed setting and documentation of assessed O2 sats was reviewed at an inservice on 10-13-16 and also at an inservice for Licensed Nursing staff on 10-25-16.	10/31/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135070	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/07/2016
NAME OF PROVIDER OR SUPPLIER BEAR LAKE MEMORIAL SKILLED NURSING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 164 SOUTH FIFTH STREET MONTPELIER, ID 83254		
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F 328	<p>Continued From page 27 included a 7/6/16 revision for PRN O2 at 2 LPM "in room on wall oxygen" and 3 LPM "out of room on portable concentrator."</p> <p>A 7/6/16 physician's order documented O2 at 2 LPM "(wall)" or 3 LPM "(portable concentrator)" PRN for shortness of breath and to notify the physician if unable to maintain O2 sats greater than 90% with the O2 between 2-4 LPM.</p> <p>Weekly O2 sats for 7/6/16 to 10/5/16 were documented between 92% and 99%. However, the documentation did not include the O2 liter flow rate when the O2 sats were checked.</p> <p>On 10/4/16 from 9:50 am to 10:30 am, 11:00 am and 11:10 am, Resident #2 was observed with a NC in place and connected to the wall O2 cylinder in his/her room which was turned on and set at 3 LPM. A tiny sign by the O2 wall cylinder in the room said to keep the O2 at 3 LPM.</p> <p>The wall O2 cylinder in Resident #2's room was observed turned on and set a 3 LPM when the resident was not in the room at 7:45 am, 3:15 pm and 4:40 pm on 10/4/16 and at 11:05 am, 2:30 pm, and 2:50 pm on 10/5/16.</p> <p>On 10/4/16 at 9:50 am, Resident #2 said s/he used O2 "almost all the time now" and "It's at 3 [LPM]." The resident said s/he used O2 from the wall</p> <p>On 10/5/16 at 2:50 pm, the DNS accompanied the surveyor to Resident #2's room. The resident was not in the room but the wall O2 cylinder was on and set at 3 LPM. The DNS said the sign by the wall cylinder was not changed when the order</p>	F 328	<p>Random audits will be conducted by the Administrator, DNS or other member of the QA team daily for one week then weekly for 4 weeks then monthly for 3 months then quarterly thereafter.</p>		

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NAME OF PROVIDER OR SUPPLIER BEAR LAKE MEMORIAL SKILLED NURSING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 164 SOUTH FIFTH STREET MONTPELIER, ID 83254		
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F 328	<p>Continued From page 28</p> <p>changed. The DNS changed the wall O2 cylinder from 3 LPM to 2 LPM and said the sign would be changed.</p> <p>2. Resident #1 was admitted to the facility in August 2011, with multiple diagnoses, including OSA, and SOB.</p> <p>The Annual MDS assessment, dated 2/2/16, documented Resident #1 received oxygen [O2] therapy.</p> <p>Resident #1's O2 care plan interventions, initiated 3/16/15, and revised on 7/26/15, documented staff were to provide oxygen at 4 LPM, assess O2 saturations when assessing vital signs and as necessary for respiratory problem; and notify the physician if the resident's saturations fell below 90%,</p> <p>A physician's orders, dated 8/17/15, documented Resident #1 was to receive O2 per NC at 4 LPM continuously to maintain saturation levels at 90% or greater. Staff were to assess Resident #1's blood-oxygen saturation levels weekly, and as needed, for respiratory distress. Resident #1's record did not contain, and the facility could not provide, oxygen orders preceding those issued on 8/17/15.</p> <p>On 10/5/16 at 4:00 pm, the DNS stated, "We would be checking the SATS weekly if they are on O2."</p> <p>Resident #1's Weights and Vitals Summary provided by the facility documented blood-oxygen saturation levels were not monitored weekly during the following time</p>	F 328			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135070	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/07/2016
NAME OF PROVIDER OR SUPPLIER BEAR LAKE MEMORIAL SKILLED NURSING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 164 SOUTH FIFTH STREET MONTPELIER, ID 83254		
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F 328	Continued From page 29 frames: * 12/3/14 - 5/26/15 * 6/23/15 - 7/19/15 * 8/25/15 - 9/15/15 * 9/29/15 - 10/27/15 * 10/20/15 - 11/30/15 * 12/2/15 - 12/15/15 * 12/29/15 - 1/11/16 * 1/13/16 - 1/25/16 * 3/7/16 - 3/21/16 * 4/11/16 - 4/25/16	F 328			
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions	F 441		10/31/16	

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NAME OF PROVIDER OR SUPPLIER BEAR LAKE MEMORIAL SKILLED NURSING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 164 SOUTH FIFTH STREET MONTPELIER, ID 83254		
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F 441	<p>Continued From page 30</p> <p>from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and P&P review, it was determined the facility failed to ensure licensed nursing staff properly sanitized or washed their hands before and after direct contact with residents and when passing medications, including eye drops, to residents. This was true for 2 of 10 sample residents (#1 & #2) and 1 random resident (#11). The deficient practice created the potential for the spread of infectious organisms from cross contamination which could harm all residents residing in the facility. Findings include:</p> <p>1. On 11/4/16 at 10:55 am, LPN #2 was observed as she handled the lock on the refrigerator at the nurses' station with her bare hands. Immediately afterward, the LPN opened the medication cart, removed a container of eye drops, closed and locked the medication cart, then walked to Resident #2's room. The LPN knocked on Resident #2's open door then entered the room and walked to Resident #2 who</p>	F 441	<p>LN's #1 and #2 were educated on the importance of proper hand hygiene on 10-7-16. All licensed nursing staff were educated at Licensed in-service on 10-25-16 and all staff at in-service on 10-13-16.</p> <p>All residents have the potential for infections if proper hand hygiene is not completed as required</p> <p>Hand hygiene audits will be completed as follows: Licensed Nursing staff will be required to observe hand hygiene performed by C.N.A.'s at least twice per shift and Administrative staff will observe hand hygiene of Licensed Nursing staff at least twice per shift daily. The Infection control committee will review the Hand hygiene observations and make recommendations and assignments based on the results of the observations.</p>		

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F 441	<p>Continued From page 31</p> <p>was sitting in a recliner by the window. The LPN did not wash or sanitize her hands before she put on gloves and administered 1 eye drop in each eye. She did not remove the gloves. She then removed Resident #2's right leg compression stocking, removed 2 Band-Aids from the right great toenail area, retrieved 2 Band-Aids from her scrub top pocket, and applied them to the right great toenail area. She did not remove the gloves. She then pulled up Resident #2's right pant leg and removed a Band-Aid from the right mid shin. LPN #2 said she would ask LPN #1 to look at Resident #2's shin before she redressed it. She did not remove the gloves. She removed Resident #2's left heel lift boot and pressed the heel to check for blanching. After that, the LPN removed the gloves and sanitized her hands with sanitizer from a dispenser on the wall then left the room.</p> <p>On 11/4/16 at 11:10 am, LPN #1 and LPN #2 were observed as they entered Resident #2's room. LPN #2 used hand sanitizer from the wall dispenser in the resident's room. LPN #1 did not perform hand hygiene before she applied a glove on her right hand, pulled up Resident #2's right pant leg using both hands, and touched the mid shin area with the gloved hand. LPN #1 suggested a treatment for the shin, removed the glove, sanitized her hands with sanitizer from the wall dispenser then she and LPN #2 left the room.</p> <p>On 11/4/16 at 11:15 am, LPN #2 was observed when she returned to Resident #2's room. LPN #2 did not perform any type of hand hygiene before she applied gloves, cleansed the right mid shin area, applied an ointment and non-adherent</p>	F 441	<p>All staff will receive education related to infection control, with emphasis on hand hygiene at monthly in-service meetings.</p> <p>Review of hand hygiene observations will be conducted weekly for 4 weeks then monthly for 3 months then quarterly thereafter</p>		

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NAME OF PROVIDER OR SUPPLIER BEAR LAKE MEMORIAL SKILLED NURSING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 164 SOUTH FIFTH STREET MONTPELIER, ID 83254		
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F 441	<p>Continued From page 32</p> <p>dressing to the right mid shin area, and then reapplied Resident #2's compression stocking. LPN #2 did not remove the gloves. She then handled the lift recliner control, assisted Resident #2 to stand, maneuvered the resident's walker into place, opened the bathroom door and assisted Resident #2 into the bathroom. A few moments later, LPN #2 exited the bathroom, removed the gloves, sanitized her hands with sanitizer from the wall dispenser, and left the room.</p> <p>On 11/4/16 at 11:20 am, when informed of the observations of no hand hygiene, LPN #2 said she had used sanitized from the wall dispenser in Resident #2's room before she administered the eye drops.</p> <p>2. On 10/4/16 at 7:56 am, LPN #2 was observed administering 8 morning medications to Resident #11. LPN #2 brought the medications from the medication cart to Resident #11's room, where she gripped the door handle, rearranged several items on Resident #11's bedside table, and administered the medications. LPN #2 was not observed to wash or sanitizing her hands prior to, or following, the medication administration to Resident #11.</p> <p>On 10/4/16 at 11:55 a.m., LPN #2 stated her hands were full and she did not wash them prior to, or following, the 7:56 am medication administration to Resident #11.</p> <p>3. On 10/4/16 at 11:15 am, LPN #1 was observed administering 2 medications to Resident #1. LPN #1 was observed unlocking and opening the room where the medication cart was stored,</p>	F 441			

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135070	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/07/2016
NAME OF PROVIDER OR SUPPLIER BEAR LAKE MEMORIAL SKILLED NURSING FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 164 SOUTH FIFTH STREET MONTPELIER, ID 83254		
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F 441	Continued From page 33 touching several areas of the cart, closing and locking the secured area, and gripping the handle to Resident #1's room prior to the administration of medications, including eye drops. LPN #1 was not observed to wash or sanitizing her hands prior to, or following, the medication administration. On 10/4/16 at 1:30 pm, LPN #1 stated she did not wash or sanitize her hands before administering eye drops to Resident #1, and noted the need to store the medication cart in a secured area due to the cart's broken lock disrupted her routine.	F 441		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001030	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/07/2016
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NAME OF PROVIDER OR SUPPLIER BEAR LAKE MEMORIAL SKILLED NURSING F/	STREET ADDRESS, CITY, STATE, ZIP CODE 164 SOUTH FIFTH STREET MONTPELIER, ID 83254
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	<p>16.03.02 INITIAL COMMENTS</p> <p>The following deficiencies were cited during the state licensure survey conducted at the facility from October 3, 2016 to October 7, 2016.</p> <p>The surveyors conducting the survey were Linda Kelly, RN, Team Coordinator; David Scott, RN; and, Marci Clare, RN.</p>	C 000		
C 672	<p>02.150,03,c Staff Knowledge of Infection Control</p> <p>c. Exhibited knowledge by staff in controlling transmission of disease. This Rule is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure staff responsible for overseeing its infection control program were knowledgeable of current practices, incorporated data into a trending of infectious diseases among residents, and fully participated in processes intended to identify and prevent the spread of infection within the facility. Findings include:</p> <p>Infection [Committee] Control Meetings Attendance Logs documented the facility's Infection Control Coordinator did not attend 11 of 13 meetings of the Committee, whose stated goal was to "protect residents, co-worker[s], and community [members] from infectious programs, from 6/28/16 through 9/27/16. The Attendance Log for this period also documented the facility's Medical Director failed to attend 11 of the 13 meetings.</p> <p>On 10/6/16 at 8:25 am, the Infection Control Coordinator stated she worked night shifts and was unable to regularly attend Committee meetings, where infection control practices,</p>	C 672	<p>The infection control nurse will meet weekly with the DNS and Administrator to review infection surveillance data and other infection control related data.</p> <p>All residents have the potential to be affected if the facility does not have a functional infection control program</p> <p>The facility's infection control plan has been revised and updated to provide guidance to the infection control nurse and infection control committee on steps that must be taken to identify and prevent the spread of infections in the facility. The infection control nurse and DNS will be provided with more opportunities to attend educational sessions related to infection control.</p> <p>The Infection control nurse will meet with the Administrator and DNS weekly and will attend Monthly infection control meetings with the infection control committee, including the facility Medical</p>	10/31/16

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 10/27/16
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Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001030	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/07/2016
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NAME OF PROVIDER OR SUPPLIER BEAR LAKE MEMORIAL SKILLED NURSING F/	STREET ADDRESS, CITY, STATE, ZIP CODE 164 SOUTH FIFTH STREET MONTPELIER, ID 83254
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C 672	<p>Continued From page 1</p> <p>surveillance, policies, practices, and facility-wide trending of infections within the facility were discussed. Additionally, the Infection Control Coordinator stated the following:</p> <ul style="list-style-type: none"> * She did not compile or maintain infection control trending data or analyses. Trending of infections within the facility were maintained by the Administrator, whose records did not contain specific information related to organism types or means of transference (contact, airborne, droplet). * She did not know how non-nursing staff's signs/symptoms of illness or infection was reported or responded to for the dietary, housekeeping, or maintenance staff. * Alcohol-based cleaning solutions, rather than germicidal-based agents, were sufficient to sanitize durable medical equipment, such as glucometers, used between multiple residents. * She relied solely on observations by the DNS and MDS Coordinator to ensure nursing staff practiced universal precautions and applicable infection control practices among residents in general as well as those residents placed under isolation conditions due to contagious infection. <p>On 10/6/16 at 3:45 pm, the DNS stated she attempted to observe infection control practices among nursing staff on all shifts, but could not provide documentation this process was enacted. The DNS stated she was not able to conduct the "spot checks" on nursing staff "very often, and noted the Infection Control Coordinator did not regularly attend the Infection Control Committee's meetings nor confer regularly with other Committee members due to conflicting shift schedules.</p>	C 672	Director. Infection reports and other data will be reviewed weekly by the DNS, Administrator and other members of the infection control committee.	
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