



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR  
LICENSING & CERTIFICATION  
DEBBY RANSOM, R.N., R.H.I.T – Chief  
BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, Idaho 83720-0009  
PHONE: (208) 334-6626  
FAX: (208) 364-1888  
E-mail: [fsb@dhw.idaho.gov](mailto:fsb@dhw.idaho.gov)

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May 17, 2017

Bonnie Sorensen, Administrator  
Countryside Care & Rehabilitation  
1224 8th Street  
Rupert, ID 83350-1527

Provider #: 135064

Dear Ms. Sorensen:

On **May 4, 2017**, 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 a widespread deficiency 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.

Bonnie Sorensen, Administrator  
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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 **May 30, 2017**. Failure to submit an acceptable PoC by **May 30, 2017**, may result in the imposition of penalties by **June 21, 2017**.

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 **June 8, 2017 (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 **August 2, 2017**. A change in the seriousness of the deficiencies on **June 18, 2017**, may result in a change in the remedy.

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The remedy, which will be recommended if substantial compliance has not been achieved by **August 2, 2017** includes the following:

Denial of payment for new admissions effective **August 2, 2017**. [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 **October 31, 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.

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 **August 2, 2017** 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>

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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 **May 30, 2017**. If your request for informal dispute resolution is received after **May 30, 2017**, 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,

A handwritten signature in black ink that reads "D. Scott". The signature is written in a cursive style with a large initial "D" and a smaller "Scott" following it.

David Scott, R.N., Supervisor  
Long Term Care

DS/lj  
Enclosures

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

PRINTED: 06/08/2017  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135064</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>05/04/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>COUNTRYSIDE CARE &amp; REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1224 EIGHTH STREET RUPERT, ID 83350</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	<p><b>INITIAL COMMENTS</b></p> <p>The following deficiencies were cited during the federal recertification survey conducted at the facility from May 1, 2017 to May 4, 2017.</p> <p>The surveyors conducting the survey were:</p> <p>Brad Perry, LSW, Team Coordinator Presie Billington, RN</p> <p>Survey Abbreviations:</p> <p>BID = Two times a day CNA = Certified Nurse Assistant DON = Director of Nursing ER = Extended Release LN = Licensed Nurse MAR = Medication Administration Record MDS = Minimum Data Set assessment MG = Milligram OT = Occupational Therapy PROM = Passive Range of Motion PT = Physical Therapy Q = Every RNA = Restorative Nursing Assistant ROM = Range of Motion R/T = Related to RT N.O. = Related to New Order S/S = Signs and symptoms TDD = Telecommunication Device for the Deaf TTY = Text Telephone (TeleType)</p>	F 000			
F 154 SS=D	<p><b>483.10(c)(1)(2)(iii)(4)(5) INFORMED OF HEALTH STATUS, CARE, &amp; TREATMENTS</b></p> <p>(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including:</p>	F 154		6/7/17	

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

TITLE

(X6) DATE

Electronically Signed

05/25/2017

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 154	Continued From page 1  (c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition.  (c)(iii) The right to be informed, in advance, of changes to the plan of care.  (c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care.  (c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is not met as evidenced by: Based on review of residents' records and staff interview, it was determined the facility failed to ensure residents receiving antipsychotic medications, and/or their interested parties, were fully informed of the potential risks related to use of the medications. This was true for 2 of 4 residents (#4 and #8) reviewed for psychoactive medications. This deficient practice placed residents at risk of life-threatening medication side effects without their knowledge and consent. Findings include:  1. Resident #4 was admitted to the facility on 6/12/16, with multiple diagnoses including dementia with behavioral disturbances.  Resident #4's Medication Reconciliation -	F 154	1. On 05/24/2017 resident #4 and resident #8 had new consent forms completed and presented to the residents representative for signature. This included the warning for risk of death in elderly patients with dementia related to psychosis because of increased risk of death from CVA or infection.  2. All residents who are taking anti psychotic medications will have a review of their consent form and a new one completed and signed if it does not include the risk of death in elderly patients with dementia related to psychosis because of increased risk of death from CVA or infection.		

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F 154	<p>Continued From page 2 Discharge/Transfer Report, dated 10/14/16, documented:</p> <p>* Quetiapine [antipsychotic] tablet 25 mg, 100 mg after the evening meal for insomnia/sleep</p> <p>Resident #4's Psychoactive Medication Consent form for Quetiapine, also know as Seroquel, was signed by Resident #4's Interested Party on 10/14/16. The consent form for Quetiapine included side effects of constipation, back pain, headache, dizziness, etc. The consent did not include the increased risk of death in elderly patients with dementia using Quetiapine.</p> <p>The Nursing 2016 Drug Handbook documented Quetiapine's Blackbox Warning as, "Drug is not indicated for use in elderly patients with dementia-related psychosis because of increased risk of death from CV [cardiovascular] disease or infection."</p> <p>On 5/4/17 at 11:45 am, the DON said the consent form for Resident #4 should have included the warning of increased risk of death in the elderly for use of Quetiapine.</p> <p>2. Resident #8 was admitted to the facility on 10/27/15, with multiple diagnoses including depression. A 5/16/16 physician progress note documented a diagnosis of dementia. A physician progress note, dated 9/14/16, documented a diagnosis of psychosis.</p> <p>Resident #8's Psychotropic Drug Committee Update documented:</p> <p>* 8/15/16 - "In a note written by [physician] it</p>	F 154	<p>3. On 05/11/2017 A revised Psychoactive Medication Consent was created to include a section to address black box warnings. Staff will be inserved on 6-5-17 concerning the new consent form and the black box warning.</p> <p>4. The DON or her representative will review all new admissions for the use of antipsychotic medications as well as all new orders for antipsychotic medication for an appropriate consent form. A QA will be done weekly until 100% has been reached for 4 weeks and then monthly until 100% for 3 months and then quarterly. The results of the QA will be reviewed by the administrator and the QI committee at the monthly Quality meeting.</p>		

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F 154	Continued From page 3 stated, 'Patient has been very frustrated. She is ready to die. She has been showing some aggressive behaviors. She broke a mirror over her head.' On 3/22/16 Olanzapine [antipsychotic] 7.5 mg was started..."  * 1/30/17 - "[Resident #8] continues on Citalopram [antidepressant] 40 mg for depression and Olanzapine 7.5 mg for bizarre behaviors and negative verbalizations..."  Resident #8's Medication Intervention Consent form for Zyprexa (Olanzapine), dated 3/21/16, documented potential side effects of sleepiness, headache, nausea and vomiting, insomnia and urticaria [hives]. The consent form also documented, "... Spoke [with Interested Party] R/T N.O. [related to new order] gave consent 3/21/16..." The consent form did not contain a warning of the increased risk of death in the elderly taking Olanzapine.  The Nursing 2016 Drug Handbook documented a Zyprexa Blackbox Warning as, "Drug may increase risk of CV [cardiovascular] or infection-related death in elderly patients with dementia. Olanzapine isn't approved to treat patients with dementia related psychosis."  On 5/4/17 at 11:45 am, the DON said the Olanzapine consent form for Resident #8 should have included the warning of increased risk of death in elderly patients with dementia.	F 154			
F 156 SS=F	483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES  (d)(3) The facility must ensure that each resident remains informed of the name, specialty, and	F 156		6/7/17	

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F 156	<p>Continued From page 4</p> <p>way of contacting the physician and other primary care professionals responsible for his or her care.</p> <p>§483.10(g) Information and Communication.</p> <p>(1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility.</p> <p>(g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including:</p> <p>(i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes -</p> <p>(A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section;</p> <p>(B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act.</p> <p>(C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the</p>	F 156			

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F 156	<p>Continued From page 5 community and the Medicaid Fraud Control Unit; and</p> <p>(D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community.</p> <p>(ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.) [§483.10(g)(4)(ii) will be implemented beginning November 28, 2017 (Phase 2)]</p> <p>(iii) Information regarding Medicare and Medicaid eligibility and coverage; [§483.10(g)(4)(iii) will be implemented beginning November 28, 2017 (Phase 2)]</p> <p>(iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program; [§483.10(g)(4)(iv) will be implemented beginning November 28, 2017 (Phase 2)]</p>	F 156			

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

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F 156	Continued From page 6  (v) Contact information for the Medicaid Fraud Control Unit; and [§483.10(g)(4)(v) will be implemented beginning November 28, 2017 (Phase 2)]  (vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community.  (g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives:  (i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and  (ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property	F 156			

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F 156	<p>Continued From page 7</p> <p>in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community.</p> <p>(g)(13) The facility must display in the facility written information, and provide to residents and applicants for admission, oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>(g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay.</p> <p>(i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility.</p> <p>(ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any.</p> <p>(iii) Receipt of such information, and any amendments to it, must be acknowledged in writing;</p> <p>(g)(17) The facility must--</p> <p>(i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of-</p>	F 156			

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F 156	<p>Continued From page 8</p> <p>(A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged;</p> <p>(B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and</p> <p>(ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in paragraphs (g)(17)(i)(A) and (B) of this section.</p> <p>(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.</p> <p>(i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.</p> <p>(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.</p> <p>(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's</p>	F 156			

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NAME OF PROVIDER OR SUPPLIER  <b>COUNTRYSIDE CARE &amp; REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1224 EIGHTH STREET RUPERT, ID 83350</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 156	<p>Continued From page 9</p> <p>per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.</p> <p>(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.</p> <p>v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on review of the facility's Admission Packet and staff interview, it was determined the facility failed to ensure its Admission Packet informed residents of all their rights while in the facility. This deficient practice effected all 38 residents in the facility and new admissions to the facility. This created the potential for harm should residents fail to realize and/or exercise those rights. Findings include:</p> <p>The following revised federal regulations issued in November 2016 were not included in the facility's Admission Packet provided to residents and/or their interested parties:</p> <p>a. The facility must have reports with respect to any surveys, certifications, and complaints investigations completed during the 3 preceding years...and post notice of the availability of such reports..."</p> <p>b. The facility's Admission Packet documented</p>	F 156	<p>1. On 05/12/2017 new updated resident rights packets were received. Residents or their representative will sign the new notice of right and it will be placed in the residents chart.</p> <p>2. All new admissions have the potential to be affected.</p> <p>3. All resident right forms will be the updated version.</p> <p>4. The billing person or her representative will do a review of all resident charts, then a QA will be done weekly to include all new admissions. A report of this review will be reviewed by the administrator and the QI committee at the monthly Quality meeting.</p>		

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F 156	<p>Continued From page 10</p> <p>the resident has the right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition, but did not include, "The resident has the right to receive notices orally and in writing (including Braille)..."</p> <p>c. The facility's Admission Packet documented the resident has the right to have reasonable access to the use of telephone where calls can be made without being overheard, but did not include, "...reasonable access to a telephone, including TTY [Text Telephone] and TDD [Telecommunication Device for the Deaf] services. This includes the right to retain and use a cellular phone at the resident's own expense."</p> <p>d. The facility's Admission Packet documented the resident had the right to privacy in written communication, including the right to receive mail unopened and the right to use a telephone in private, but did not include, "The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for Internet research."</p> <p>e. The facility's Admission Packet notified the resident's has the right to share room with his or her spouse when married residents live in the same facility and both spouses consent to the arrangement, but did not include notification to residents that they had "the right to share a room with his or her roommate of choice when practicable..."</p> <p>f. The facility's agreement notified residents they have the right to participate in social, religious,</p>	F 156			

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F 156	Continued From page 11 and community activities that do not interfere with the rights of other residents in the facility, but did not inform residents they had "a right to choose activities, schedules (including sleeping and waking times..."	F 156			
F 167 SS=C	On 5/3/17 at 1:25 pm, the Administrator said she was aware the federal regulations were revised in November 2016, but she was not aware the facility's notice of rights was not updated. 483.10(g)(10)(i)(11) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE  (g)(10) The resident has the right to-  (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and  (g)(11) The facility must--  (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility.  (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and  (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public.	F 167		6/7/17	

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F 167	Continued From page 12 (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation and Resident Group and staff interview, it was determined the facility failed to ensure a notice was posted that surveys for the three previous years were available for review. This deficient practice affected all residents, residents' representative, and visitors who may want to review survey results. Findings include:  On 5/1/17 at 2:00 pm, a survey results binder was observed on the wall opposite of the nurses station and next to the office of the Director of Nursing Services. The binder contained the most recent recertification survey, dated 2/19/16. At 2:30 pm, a survey results binder was observed on the wall in the West Dining Room. The binder contained the most recent recertification survey, dated 2/19/16. There was no notice posted that survey results and the facility's plan of correction for surveys for the past three years were available for review.  On 5/1/17 at 4:00 pm, the Administrator said she was not aware of the three year posting requirement.  On 5/2/17 at 3:00 pm, during the Resident Group interview, 8 of 8 residents in the group stated they knew where to find one of the two copies of the most recent survey result binder.	F 167	1. On May 05, 2017 a notice was placed at the front of displayed survey binder stating that the last three surveys are available and may be reviewed upon a request made to the administrator or nursing staff.  2. All residents and family members have the potential to be affected.  3. Information concerning the ability to request the last three surveys will be reviewed in resident council and weekly in PCC with resident and family. Staff will be inserviced on 6-5 and 6-6-2017 concerning requests for additional survey results.  4. Social Services or her representative will do a weekly QA of PCC and monthly resident council notes to make sure all residents are aware and the clerk will do a weekly QA to make sure the current survey results along with the notice of the availability of the last 3 surveys until 100% for 4 weeks then monthly until 100% for 3 months then monthly. A report of the this QA will be reviewed by the administrator and the QI committee at the monthly Quality meeting.		
F 246 SS=D	483.10(e)(3) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES	F 246		6/7/17	

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F 246	<p>Continued From page 13</p> <p>483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including:</p> <p>(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review, and resident and staff interviews, it was determined the facility failed to ensure residents' call lights were within reach and could be used when needed. This was true for 1 of 9 (#2) residents reviewed for call light accessibility and created the potential Resident #2 would not be able to summon staff for assistance when needed. Findings include:</p> <p>Resident #2 was admitted to the facility on 8/15/11 with multiple diagnoses including traumatic brain injury, scoliosis and torticollis [head tilted to one side].</p> <p>The 4/25/17 Quarterly MDS assessment documented Resident #2 was cognitively intact, did not speak, understood others and was clearly understood, required the assistance of two staff with transfers and bed mobility, and the assistance of one staff for eating and dressing.</p> <p>Resident #2's Care Plan documented she used a communication board to voice her needs and could respond to "yes" or "no" questions. Resident #2's Care Plan also documented she was able to use the call light appropriately, but</p>	F 246	<p>1. A clip was placed on residents call light on 05/24/2017 so it can be clipped to residents blankets within reach rather than tied to the bed rail.</p> <p>2. All residents in facility have the potential of being affected by call-lights not being within reach.</p> <p>3. Staff will be in-serviced on 06/05/2017 and 06/06/2017 on placements of the call-lights with reach and use of clips on call-lights. Clips will be ordered so they may be placed on each call-light in the facility.</p> <p>4. CNA Supervisor or her representative will do a weekly QA beginning the week of 05/29/2017 to ensure all call-lights have clips and are within reach of residents. CNA Supervisor will report QA findings to the administrator and QI committee at the monthly quality meeting.</p>		

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F 246	Continued From page 14 due to immobility required the call light to be readily accessible.  On 5/1/17 at 2:40 pm, Resident #2 was observed in bed watching television. Her call light was tied to the left upper side rail above the level of her head and was hanging on the side of the bed. Resident #2 was able to locate her call light when asked, but could not pull the hanging cord so she could use the call light. Certified Nursing Assistant (CNA) #1 entered the room and assessed Resident #2's vital signs before leaving, without placing the call light in a position that was readily accessible to Resident #2. At 3:40 pm, Resident #2's call light was observed in the same location.  On 5/1/17 at 4:15 pm, CNA #1 entered Resident #2's room, where, when asked about the resident's ability to access the call light, said she should have ensured the call light was within Resident #2's reach before leaving her room earlier in the day at 2:40 pm.	F 246			
F 318 SS=D	483.25(c)(2)(3) INCREASE/PREVENT DECREASE IN RANGE OF MOTION  (c) Mobility.  (2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.  (3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.	F 318		6/7/17	

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F 318	<p>Continued From page 15</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident and staff interviews, it was determined the facility failed to ensure a restorative nursing program to prevent functional decline in Range of Motion (ROM) was provided for 1 of 4 (#2) residents reviewed for ROM. This deficient practice had the potential to cause harm if Resident #2 experienced a decline in ROM. Findings include:</p> <p>Resident #2 was admitted to the facility on 8/15/11 with multiple diagnoses including traumatic brain injury, scoliosis and torticollis (head tilted to one side).</p> <p>A 4/25/17 Quarterly Minimun Data Set (MDS) assessment documented Resident #2 was cognitively intact, did not speak, understood others and was clearly understood, and required the assistance of 2 staff with transfers and bed mobility.</p> <p>Resident #2's Care Plan documented she used a communication board to express her needs and could respond to "yes" or "no" questions. Resident #2's Care Plan did not include a ROM care plan.</p> <p>On 5/1/17 from 10:45 am to 11:50 am, Resident #2 was observed in bed lying on her back and slightly on her left side. Her hands were contracted at the wrist and her head was tilted to the left side with a regular pillow supporting her head. A neck pillow (travel pillow) was observed on the recliner inside her room.</p>	F 318	<ol style="list-style-type: none"> <li>1. On 05/08/2017 PT did a screen of resident #2 for neck and upper extremity contractures and initiated a restorative program. On 05/09/2017 OT did a screen of resident #2 for neck and upper extremity contractures with no further OT required at this time.</li> <li>2. All residents with contractures have the potential to be affected.</li> <li>3. All residents with contractures will be evaluated for a restorative program. On 06/05/2017 and 06/06/2017 staff will be in-serviced regarding residents with contractures and ROM and referring residents to a restorative program. Restorative Aids will do the ROM initially and then train the CNA's for each residents ROM as needed.</li> <li>4. Beginning the week of 05/29/2017 the DON or her representative will do a weekly QA of 5 residents utilizing the "Contracture Risk Assessment" tool to identify residents that may be at risk for contractures until all of the residents have been reviewed. Then a monthly QA of residents with MDS reviews. A report will be sent to the administrator and the QI committee to be reviewed at the monthly quality meeting.</li> </ol>		

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F 318	<p>Continued From page 16</p> <p>On 5/2/17 at 10:50 am, CNA #2 said Resident #2 received Passive Range of Motion (PROM) exercises daily that involved stretching the extremities, but not the neck. CNA #2 stated these exercises were usually provided in the morning, but at times Resident #2 refused to participate.</p> <p>On 5/3/17 at 9:05 am, Resident #2 was observed on her bed lying on her back with a regular pillow supporting her head. Resident#2's head was tilted to her left side, her right hand was extended at the wrist, and her left hand was flexed at the wrist. Resident #2's right arm was flexed to her chest but she was able to raise it slowly when asked. Resident #2 was not able to open her right hand to show her palm; Resident #2 was able to open her left hand enough to hold a drinking cup. Resident #2 was not equipped with a hand splint for her right hand at the time of this observation.</p> <p>On 5/3/17 at 9:55 am, the Director of Nursing (DON) said Resident #2 participated in an Restorative nursing program in which a CNA provided PROM exercises. The DON stated CNAs would only perform PROM exercises on Resident #2's extremities, but not on her neck. The DON said she could not remember the last time Resident #2 was seen by a Physical Therapist (PT) or Occupational Therapist (OT), but said she recalled Resident #2 refused many such treatments in the past.</p> <p>On 5/3/17 at 1:55 pm, Resident #2 did not move her head when asked if her extremities were being exercised. When asked if she would like her extremities exercised, Resident #2 smiled</p>	F 318			

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F 318	<p>Continued From page 17 and pointed to "Yes" on a paper with "Yes" and "No" written on it.</p> <p>On 5/3/17 at 2:40 pm, PT #1 said the last time she assessed and treated Resident #2 was in 2015, and remembered her with a significant degree of neck bending to the left and contractures to her extremities. PT #1 said the therapy program for Resident #2 was discontinued as she had reached a "plateau," but a maintenance program should have been provided as Resident #2 had a "significant chance" of further decline if ROM exercises were not performed.</p> <p>On 5/3/17 at 3:30 pm, the DON asked Resident #2 if she would like to participate in ROM exercises, to which Resident #2 nodded her head "yes."</p> <p>Resident #2 was observed on the following dates and times lying in bed using a regular pillow to support her head and no hand splint on her right hand:</p> <ul style="list-style-type: none"> <li>* 5/1/17 at 1:40 pm, 2:40 pm, 3:40 pm</li> <li>* 5/2/17 at 8:00 am, 9:50 am, 10:50 am</li> <li>* 5/3/17 at 9:05 am, 1:55 pm</li> </ul> <p>On 5/4/17 at 1:30 pm, LPN #2 said Resident #2 had tried the neck pillow but she believed the resident was removing it whenever it was placed on her neck. CNA #3, also present, said she did not know whether Resident #2 needed the neck pillow or not.</p> <p>On 5/4/17/at 1:45 pm, LPN #2 and CNA #2 were observed in Resident #2's room, where LPN #2</p>	F 318			

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F 318	Continued From page 18 took the neck pillow from the recliner and asked her if she would like to use it. Resident #2 moved her head up and down and CNA #2 placed the neck pillow under Resident #2's neck, where Resident #2 attempted to position it. When LPN #2 asked Resident #2 if she liked the pillow, Resident #2 smiled.	F 318			
F 329 SS=E	On 5/4/17 at 2:10 pm, the DON said she would ask PT and OT to reassess Resident #2. 483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS  483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used--  (1) In excessive dose (including duplicate drug therapy); or  (2) For excessive duration; or  (3) Without adequate monitoring; or  (4) Without adequate indications for its use; or  (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or  (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.  483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that--	F 329		6/16/17	

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F 329	Continued From page 19  (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;  (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on review of residents' records and staff interview, it was determined the facility failed to ensure residents' receiving psychoactive medications had clear indications for use of the medications and rationale supporting the continued use of the medications at the same dosage. This was true for 2 of 4 residents (#2 and #4) sampled for the use of psychoactive medications. The deficient practice had the potential for more than minimal harm should medications not have their desired effect, lead to adverse consequences, or if residents received excessive dosages over prolonged periods of time. Findings include:  1. Resident #2 was admitted to the facility on 8/15/11, with multiple diagnoses, including traumatic brain injury.  The 1/31/17 Annual Minimum Data Set (MDS), and 4/25/17 Quarterly MDS assessment documented Resident #2 was cognitively intact and had no behaviors.	F 329	1. For resident #2 the pharmacist will talk to the physician about the need for a gradual dose reduction. For resident #4 a memo was sent on 5-24-17 to the physician for an appropriate diagnosis for her medication.  2. All residents who receive psychoactive medications have the potential to be affected. All residents with psychoactive medications will have their records reviewed for appropriate gradual dose reductions.  3. Staff will be in-serviced on 06/05/2017 for requesting a Diagnosis with medication orders. Psychotropic Drug Committee review sheets that have been revised to include explanation for not making changes and a diagnosis section.  4. The DON or her representative will review all resident charts with psychoactive medications for appropriate		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135064</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>05/04/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>COUNTRYSIDE CARE &amp; REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1224 EIGHTH STREET RUPERT, ID 83350</b>		
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F 329	<p>Continued From page 20</p> <p>Resident #2's Care Plan documented, "Potential for increased depression related to physical limitations due to disease process." Interventions documented Resident #2 was to receive antidepressant medication as ordered; staff were to contact the physician if Resident #2's signs and symptoms of depression, such as tearfulness, decreased social interaction, and/or decreased appetite worsened; Resident #2 was to use a communication board to voice her needs; she was to receive one-to-one visits with staff; and antidepressant use was to be reviewed by facility's psychotropic committee.</p> <p>Resident #2's April 2017 recapitulated physician's order documented:</p> <ul style="list-style-type: none"> <li>* Effexor Extended Release (ER) 75 milligram (mg ) twice daily, started on 4/15/15</li> <li>* Paxil 20 mg once daily, started on 4/26/17</li> </ul> <p>The February and March 2017 Behavior Monitoring Sheet documented Resident #2 had no behaviors.</p> <p>Resident #2's Psychotropic Drug Committee Updates documented:</p> <p>*10/20/16 - "Paxil 40 mg every (Q) day and Venlafaxine [Effexor] 75 mg two times a day (BID). She does not come out of her room except for special occasions such as Halloween...She has had no documented behaviors or s/s [signs/symptoms] of increased depression for the past three months. She continues to be stable on the current dose..."</p> <p>*1/30/17 - "Paxil 40 mg every (Q) day and</p>	F 329	<p>diagnosis and gradual dose reductions quarterly with the psychotropic committee quarterly reviews. A QA will be done weekly on all admissions and new orders for diagnosis and reductions until 100% has been reached for 3 weeks then monthly. Findings will be reported to the administrator and the QI committee to be reviewed at the monthly Quality meeting.</p>		

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F 329	<p>Continued From page 21</p> <p>Venlafaxine 75 mg two times a day (BID)...She spends her days in her room watching TV per her requests...There has not been an attempt to reduce these doses. The committee is requesting that we reduce the evening dose of Effexor from 75 mg to 37.5 mg and monitor for changes in mood and behavior."</p> <p>The physician's response, dated 1/30/17, documented, "No changes please." There was no explanation found in Resident #2's clinical record explaining the physician's decision not to reduce the Effexor from 75 mg to 37.5 mg.</p> <p>On 5/3/17 at 2:10 pm, the Director of Nursing (DON) said she did not ask the physician for an explanation for not agreeing with the Psychotropic Drug Committee's recommendation to reduce Resident #2's Effexor from 75 mg to 37.5 mg.</p> <p>2. Resident #4 was admitted to the facility on 6/12/16, with multiple diagnoses including dementia with behavioral disturbances.</p> <p>Resident #4's Medication Reconciliation - Discharge/Transfer Report, dated 10/14/16, documented:</p> <p>* Venafaxine Extended Release (ER) 37.5 mg twice daily for depression/pain * Quetiapine tablet 25 mg, 100 mg after the evening meal for insomnia/sleep</p> <p>Resident #4's Psychotropic Drug Committee Update, dated 5/1/17, documented, "Venlafaxine 37.5 mg BID [for]: depression/pain, Quetiapine 100 mg q pm [for]: sleeplessness...[Resident #4]</p>	F 329			

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F 329	Continued From page 22 has had increased behaviors toward staff which include hitting, spitting, kicking, refusing medications and treatments..."  The Nursing 2016 Drug Handbook documented Quetiapine's Indications for Use include schizophrenia, bipolar disorder, depression associated with bipolar disorder, major depressive disorder, and obsessive-compulsive disorder.  The use of Quetiapine to increase a person's ability to sleep is not a standard indication for use of the medication.  On 5/4/17 at 11:45 am, the DON said the nurse who received the transfer order should have clarified the indication of the medications with the physician.	F 329			
F 372 SS=F	483.60(i)(4) DISPOSE GARBAGE & REFUSE PROPERLY  (i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure the outside trash dumpster area was free from debris and insects. This created the potential for harm should rodents and/or insects attracted to exposed contents adversely affect the ability of 1 or more of the 38 residents living in the facility, to live comfortably without unwanted pests. Findings include:  On 5/4/17 from 9:35 am to 9:50 am, during an environmental tour with the Director of Environmental Services, 5 outside trash	F 372	1. On 5-22-17 the trash dumpster area was cleaned.  2. All residents have the potential to be affected as well as the facility staff and visitors.  3. Area will be checked by maintenance daily for loose garbage, open lids and cleaned as needed. Staff will be educated on 06/05/2017 and 06/06/2017 for the proper disposal of garbage.	5/25/17	

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F 372	Continued From page 23 dumpsters were observed. Two of the 5 trash dumpsters had opened lids with trash bags piled above the lids. The following trash debris littered the ground to the front, sides, and back of the dumpsters:  * 15 used exam gloves, * A small plastic cup with approximately 80 ants in or around the cup, * A used medical specimen bag, * A plastic knife, used straws, and a soda can.  On 5/4/17 at 9:40 am, the Director of Environmental Services said the area "should not look like this." He said the plastic cup may have contained food since ants were attracted to it, but that the facility contracted with a local pest control company that came to the facility at least once a month and when needed. He said the other trash was probably blown out of the dumpsters since the lids had been left opened. He said trash pick-up happened every afternoon week-days. During the interview, the Director of Environmental Services did not close the opened lids.  On 5/4/17 at 10:15 am, the 2 trash dumpster lids were observed opened and 3 more large trash bags had been added to 1 of the 2 dumpsters. The trash dumpster next to it was observed quarter-filled with trash and with its lid closed.	F 372	4. The facilities director or a representative will do a weekly QA of the area. Weekly QA's will be reported to the Administrator and the QI committee for review at the monthly Quality meeting.		
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS  (a) Infection prevention and control program.  The facility must establish an infection prevention and control program (IPCP) that must include, at	F 441		6/7/17	

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F 441	<p>Continued From page 24 a minimum, the following elements:</p> <p>(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2);</p> <p>(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p>	F 441			

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F 441	Continued From page 25  (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and  (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.  (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.  (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.  (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure hand hygiene was provided to residents after toileting. This was true for 1 of 9 residents (#3) reviewed for toileting and created the potential for harm should residents either spread pathogens, or come into contact with, contaminated surfaces. It was also determined the facility failed to observe standard infection control practices during medication pass. This was true for 1 of 8 residents (#9) observed during medication pass and created the potential for residents to come into contact with infectious agents from cross-contamination. Findings include:	F 441	1. Resident #3 was assessed for sign and symptoms of infection r/t poor hand washing after toileting. No evidence of infection was found. Resident #9 was assessed for signs and symptoms of infection r/t ingesting medications set on table without a barrier. No evidence of infection found.  2. All residents who all or part of involvement of toileting have the potential to be affected. Will refer to MDS for residents who are assist with toileting. All residents who take medication independently have the potential to be		

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F 441	<p>Continued From page 26</p> <p>1. Resident #3 was admitted to the facility on 12/15/15, with multiple diagnoses including hypertension and heart failure.</p> <p>Resident #3's Quarterly Minimum Data Set (MDS) assessment, dated 2/21/17, documented her cognition was moderately impaired, she was frequently incontinent of bladder, and required the assistance of one staff for most for bed mobility, transfers, hygiene, and toileting.</p> <p>On 5/2/17 at 3:40 pm, Certified Nursing Assistant [CNA] #1 was observed changing Resident #3's soiled adult brief while she was seated on the toilet. Resident #3 was observed wiping herself with toilet paper. CNA#1 asked Resident #3 if she needed help in cleaning herself, to which Resident #3 said she had already done so. Resident #3 then stood up and CNA #1 pulled the new brief up and the resident started walking out of the bathroom with CNA #1 behind her. CNA #1 assisted Resident #3 to her recliner. The CNA did not ask Resident #3 to wash her hands or offer the use a hand sanitizer after she used the toilet.</p> <p>On 5/2/17 at 3:50 pm, CNA #1 said she should have asked Resident #3 to wash her hands after using the toilet.</p> <p>2. On 5/3/17 at 8:00 am, Licensed Nurse (LN) #1 was observed preparing medications for Resident #9. LN #1 poured 9 medications into a cup and went into the dining room where he poured the medications onto the table and used the cup to arrange the pills into a straight line. There was no barrier between the pills and the</p>	F 441	<p>affected.</p> <p>3. Staff will be in-serviced on 06/05/2017 and 06/06/2017 r/t washing residents hands to prevent spread of infection after toileting. In Resident Council on 05/25/2017 staff will discuss with residents the importance of washing hands and reminding staff if this step is missed. Staff will be in-serviced at staff meeting on 06/05/2017 r/t passing medications and the need for a barrier between medications and placing a clean paper towel on the table prior to placing medications on the table for the resident to take.</p> <p>4. The CNA Supervisor or her representative will do a weekly QA while residents are being toileted to ensure hand hygiene is being performed beginning the week of 05/29/2017. The DON or her representative will do a weekly QA for 1 month beginning 05/29/2017 to ensure a barrier is placed between the table and the medications, when 100% is reached then monthly for 3 months or until 100% is reached then quarterly. CNA Supervisor and DON will report findings to Administrator and QI committee at the monthly quality meeting.</p>		

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

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F 441	Continued From page 27 table as Resident #9 ingested the medications one pill at a time.  On 5/3/17 at 8:10 am, LN #1 said, "That's how she wanted me to put her medications on the table so she can take them one at a time. I guess I should have put a napkin first on the table."	F 441			

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001490</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/04/2017</b>
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C 000	<p>16.03.02 INITIAL COMMENTS</p> <p>The following deficiencies were cited during the State licensure survey of your facility, conducted from May 1, 2017 to May 4, 2017.</p> <p>The surveyors conducting the survey were:</p> <p>Brad Perry, LSW, Team Coordinator Presie Billington, RN</p>	C 000		
C 492	<p>02.121,05,d,ix Meet Window Requirments</p> <p>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 observation, and resident and staff interview, it was determined the facility failed to ensure resident rooms on the West hall had windows which opened. This affected 2 of 9 (#1 &amp; #9) sampled residents and all other residents who resided on the West hall. Findings include:</p> <p>On 5/1/17 at 10:55 am, 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 this requirement.</p> <p>On 5/1/17 from 11:00 am to 11:25 am, during the initial tour of rooms 301 through 317, the windows were observed and could not be opened. Several residents who resided in these rooms said there were no concerns regarding</p>	C 492	Continue window waiver for rooms 301 - 317	6/7/17

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  Electronically Signed	TITLE	(X6) DATE <b>05/25/17</b>
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Bureau of Facility Standards

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C 492	Continued From page 1 their windows.	C 492		
C 664	<p>02.150,02,a Required Members of Committee</p> <p>a. Include the facility medical director, administrator, pharmacist, dietary services supervisor, director of nursing services, housekeeping services representative, and maintenance services representative. This Rule is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure the Director of Nursing, Dietary Manager or Dietitian, and Maintenance Supervisor participated in the facility's Infection Control Committee meetings. This failure had the potential to adversely affect all residents, staff and visitors to the facility. Findings include:</p> <p>On 5/3/17 at 3:55 pm, the Administrator, who was also the Infection Control Nurse, said the facility held their Infection Control Meetings on a quarterly basis. Attendance sheets for the last four quarterly meetings documented the Director of Nursing and representatives from the Dietary Department had not attended any of the quarterly meetings, and the Maintenance Department did not attend the 7/18/16 quarterly meeting.</p> <p>The Administrator said minutes of the Infection Contol Committee meetings were discussed at the monthly Quality Assurance meetings with representatives from each department in attendance, including the Director of Nursing.</p>	C 664	<p>The DON and Dietary Manager have been placed on the list to attend the quarterly Infection Control Committee meetings.</p> <p>2. All residents have the potential to be effected. There were no reported adverse effects</p> <p>3. DON and Dietary Manager will attend the infection control committee meetings held quarterly.</p> <p>4. A weekly QA will be done of the meeting minutes to ensure appropriate staff attends. This will be reported to the Administrator and the monthly QI Committee.</p>	6/7/17