



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RUSS BARRON – 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

July 12, 2017

Shon Shuldberg, Administrator
Ashton Living Center
Po Box 838
Ashton, ID 83420-0838

Provider #: 135097

Dear Mr. Shuldberg:

On **June 29, 2017**, a survey was conducted at Ashton Memorial Living Center 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.

Shon Shuldberg, Administrator
July 12, 2017
Page 2

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 **July 22, 2017**. Failure to submit an acceptable PoC by **July 22, 2017**, may result in the imposition of penalties by **August 23, 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 **August 3, 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 **September 27, 2017**. A change in the seriousness of the deficiencies on **August 13, 2017**, may

Shon Shuldberg, Administrator
July 12, 2017
Page 3

result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **September 27, 2017** includes the following:

Denial of payment for new admissions effective **September 27, 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 **December 26, 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 **September 27, 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:

Shon Shuldberg, Administrator
July 12, 2017
Page 4

<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 **July 22, 2017**. If your request for informal dispute resolution is received after **July 22, 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,



Nina Sanderson, LSW, Supervisor
Long Term Care

ns/dr

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

PRINTED: 08/02/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135097	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/29/2017
NAME OF PROVIDER OR SUPPLIER ASHTON MEMORIAL LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 700 NORTH SECOND STREET ASHTON, ID 83420		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS The following deficiencies were cited during the federal recertification survey conducted at the facility on June 26, 2017 to June 29, 2017. The surveyors conducting the survey were: Jenny Walker, RN, Team Coordinator Melanie Tatom, RN Abbreviations: ADL = Activities of Daily Living CDM = Certified Dietary Manager CNA = Certified Nursing Assistant DNS = Director of Nursing DS = Dietary Supervisor IPCP = Infection Prevention and Control Program LN = Licensed Nurse MDS = Minimum Data Set mg = Milligrams	F 000			
F 241 SS=D	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to promote dignity for 2 of 6 residents (#2 and #5) reviewed for dining practices. This created the potential for harm if residents became embarrassed or angry when staff placed clothing protectors on them without	F 241	Preparation and/or execution of the plan of correction does not constitute admission of agreement the provider of the truth of the facts alleged or conclusions set forth in statement	8/3/17	

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

TITLE

(X6) DATE

Electronically Signed

07/21/2017

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135097	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/29/2017
NAME OF PROVIDER OR SUPPLIER ASHTON MEMORIAL LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 700 NORTH SECOND STREET ASHTON, ID 83420		
(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 241	<p>Continued From page 1 ascertaining their preferences.</p> <p>Findings include:</p> <p>1. On 6/27/17 at 11:50 am, CNA # 2 assisted Resident #2 to her table in the dining room, and placed a terrycloth clothing protector around Resident #2's neck. Resident #2 picked up a glass with her right hand and begin sipping water. At 12:08 p.m. the Certified Dietary Manager (CDM) placed a plate of food in front of Resident #2. Resident #2 picked up her fork and began eating the corn from her plate. After finishing the corn, Resident #2 then moved to the fruit in dessert cup. By 12:15 p.m., Resident #2 had finished the fruit cup. Her clothing protector remained in place with no visible spillage on it. At 12:20 p.m., Dietary Staff (DS) #1 rotated Resident #2's plate and prompted Resident #2 to eat her meat and mashed potatoes. With her fork in her right hand and a half piece of bread in her left hand, Resident #2 continued eating her meal of Salisbury steak with onion gravy and mashed potatoes. By 12:27 p.m. Resident #2 had eaten all of her meat and was finishing the mashed potatoes. There was no spillage on her clothing protector.</p> <p>On 6/28/17 at 11:55 am, Resident #2 was seated in the dining room with a terrycloth clothing protector around her neck. Resident #2 began to feed herself lunch which included fish, cabbage, tomato slices, bread, and lemon whip in a cup. At 12:10 p.m., Resident #2 was using her fork to eat tomato slices. There was no spillage on her clothing protector.</p> <p>Resident #2's care plan, dated 5/18/17,</p>	F 241	<p>Specific Resident(s)- Resident #2 Clothing Protector or Napkin is being offered to resident at every meal. Resident #5 Staff were educated and will offer the choice of a napkin or clothing protector and will remove and not replace at any time when resident demonstrates desire to not use a clothing protector.</p> <p>Other Residents - All other residents have potential to be affected</p> <p>Systemic changes - A root cause analysis was completed by DNS, Administrator and Dietary supervisor. It was determined that assessments and permissions were completed for residents to use a clothing protector, and staff training for understanding that clothing protectors need to be offered each and every time they are putting it on the resident.</p> <p>Monitor - Training occurred on 7/19/2017 to role play and discuss different ways residents may assert their preferences and how to recognize those preferences. Hand in Hand training was provided "Being with a person with dementia." Dietary Supervisor will intermittently observe all residents that may want to use a clothing protector and how the staff offers it to the residents and will document observations weekly for the next 90 days. She will report findings to the QAPI committee meeting.</p>		

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

PRINTED: 08/02/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135097	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/29/2017
NAME OF PROVIDER OR SUPPLIER ASHTON MEMORIAL LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 700 NORTH SECOND STREET ASHTON, ID 83420		
(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 241	<p>Continued From page 2</p> <p>documented she was dependent on staff due to her decline in cognition related to diagnosis of Alzheimer's. The plan documented historically Resident #2 was very particular about how she looked, and instructed to offer a clothing protector or napkin per the resident's choice.</p> <p>The staff failed to offer Resident #2 a choice of a cloth napkin, prior to placing the clothing protector on her.</p> <p>2. On 6/27/17 at 12:00 pm, CNA #2 brought Resident #5 into the dining room in his wheelchair. As CNA #2 put a terry clothing protector around Resident #5's neck, he stated, "Take this off!" while he pulled at it. CNA #2 prompted him to keep it on and asked if he wanted water as she attempted to hand him a glass of water. CNA #2 prompted Resident #5 to keep the clothing protector on when he reached towards it a second time.</p> <p>Resident #5's care plan, dated 6/22/17, documented he was not always able to communicate effectively related to his dementia. The care plan instructed staff to allow Resident #5 the time to communicate, as he is able to make appropriate requests at times; to allow him time to make decisions; and to offer a clothing protector or napkin at meals per his choice.</p> <p>On 6/29/17 at 1:50 pm, the Director of Nursing Services (DNS) stated that everyone should be offered a choice of clothing protector or napkin. For residents who cannot communicate verbally, staff should still ask, and then should proceed with putting a clothing protector on the resident if there was no response. The DNS confirmed that</p>	F 241			

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

PRINTED: 08/02/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135097	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/29/2017
NAME OF PROVIDER OR SUPPLIER ASHTON MEMORIAL LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 700 NORTH SECOND STREET ASHTON, ID 83420		
(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 241	Continued From page 3 Resident #3 was meticulous in how she ate and did not typically have food spillage. The DNS stated that perhaps Resident #2 wore the clothing protector because her husband had expressed that a neat clean appearance was important to her. The DNS stated that both clothing protectors and napkins were available for use, and that the term "clothing protector" instead of "bib" was used to help promote the dignity of those who utilized the item. He stated that staff who were in the dining room every day and knew the residents well may have become lax in remembering to actively offer a protector or a napkin every time. The DNS stated that if Resident #5 kept pulling the clothing protector off, staff should not have repeatedly reapplied it, and he should have been offered a napkin.	F 241			
F 312 SS=D	Review of the undated facility policy "Dining and Food Service" revealed "Clothing protector ' s [sic] provided per choice of resident ' s also choice of napkins at each meal." 483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure the necessary services were provided to maintain grooming and hand hygiene for 1 of 10 residents (#2) sampled for Activities of Daily Living (ADL) assistance. The deficient practice created the potential for harm if residents	F 312	Specific Resident - Resident #1 is being offered to wash her hands after cares are being provided. Other Residents - All other Residents have potential to be affected.	8/3/17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135097	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/29/2017
NAME OF PROVIDER OR SUPPLIER ASHTON MEMORIAL LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 700 NORTH SECOND STREET ASHTON, ID 83420		
(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 312	<p>Continued From page 4</p> <p>experienced infection when not assisted with hand hygiene after toileting.</p> <p>Findings include:</p> <p>On 6/27/17 at 11:30 am, CNA #s 1 and 2 transferred Resident #1 from her wheelchair to the toilet. While seated on the toilet, Resident #2 repeatedly manipulated a fastener on her pants. After Resident #2 defecated into the toilet, the CNAs prompted Resident #2 to hold the grab bar and stand while receiving perianal care. Resident #2 was dressed and returned to her wheelchair. The CNAs did not provide Resident #2 cues or assistance to perform hand hygiene. At 11:50 am Resident #2 was assisted to the dining room, where she picked up a glass and began sipping water.</p> <p>Review of Resident #2's Minimum Data Set (MDS) quarterly review, dated 5/9/17 revealed she had total dependence (requiring full staff performance every time) for personal hygiene. Personal hygiene included washing and drying of hands.</p> <p>Review of Resident #2's plan of care, dated 5/18/17, revealed she is dependent on staff for all ADL care due to her decline in cognition related to diagnosis of Alzheimer's. Staff were to provide full performance of grooming and ensure she is clean prior to bringing her out of her room.</p> <p>In an interview with the Director of Nursing Services (DNS), on 6/29/17 at 1:50 p.m., the DNS stated that Resident #2 should have been given hand hygiene after toileting and before lunch, and that he would follow up on the matter.</p>	F 312	<p>Systemic Changes - Our root cause analysis was completed by observing cares to other residents and it was determined this was an isolated incident. CNA #1 and #2 were pulled aside and talked to about offering hand hygiene. The DNS met with CNA's #1 and #2 individually discuss offering hand hygiene. It was determined that training would be conducted with all staff, specifically in offering hand hygiene to all residents after cares.</p> <p>Monitor - Training was conducted 7/19/2017 on always offering hand hygiene to all residents after providing cares. DNS or designee will monitor observe and document random cares and watch for offered hand hygiene 3X a week for 2 weeks, then weekly observations will be done completed and documented by DNS or designee for 6 more weeks to make sure offers are being made to residents. Will report findings to QAPI committee.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135097	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/29/2017
NAME OF PROVIDER OR SUPPLIER ASHTON MEMORIAL LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 700 NORTH SECOND STREET ASHTON, ID 83420		
(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 312	Continued From page 5	F 312			
F 329 SS=D	<p>Review of the facility policy, titled "Handwashing/ Hand Hygiene" dated 2/1/10, revealed residents would be encouraged to practice hand hygiene.</p> <p>Review of the undated facility policy, "Dining and Food Service", revealed residents would be provided proper hygiene before meals.</p> <p>483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>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--</p> <p>(1) In excessive dose (including duplicate drug therapy); or</p> <p>(2) For excessive duration; or</p> <p>(3) Without adequate monitoring; or</p> <p>(4) Without adequate indications for its use; or</p> <p>(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or</p> <p>(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.</p> <p>483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that--</p> <p>(1) Residents who have not used psychotropic</p>	F 329		8/3/17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135097	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/29/2017
NAME OF PROVIDER OR SUPPLIER ASHTON MEMORIAL LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 700 NORTH SECOND STREET ASHTON, ID 83420		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 329	<p>Continued From page 6</p> <p>drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;</p> <p>(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 record review and staff interview, it was determined the facility failed to ensure residents receiving psychoactive medication had resident-specific target behaviors identified and monitored, and had an appropriate indication for use for these medications . This was true for 2 of 5 (#1 and #3) sampled residents who received psychoactive medications. This deficient practice created the potential for harm if residents received medications that may result in negative outcomes, without clear indication of need. Findings include:</p> <p>1. Resident #1 was admitted to the facility on 3/13/15 with multiple diagnoses, including vascular dementia with behaviors, hydrocephalus, major depression with severe psychotic symptoms, and anxiety.</p> <p>Resident #1's quarterly MDS (Minimum Data Set) assessment, dated 6/16/17, documented Resident #1 experienced delusions and mild depression.</p> <p>The Physician Order Report, dated 6/12/17, documented Resident #1 was receiving Seroquel</p>	F 329	<p>F329</p> <p>Specific Resident -</p> <p>Resident # 1 Behavior/Mood Sheets now include resident specific target behaviors and interventions to monitor by the facility staff</p> <p>Resident # 3 - Was diagnosed on 7/2/2013 with ICD 9 290.8 Alzheimer's with psychosis by Dr. Larry Severa, M.D. When completing our root cause analysis that diagnosis was put in the resident's chart in our EHR program but surveyors were asking for everything to be printed and that ICD 9 diagnosis did not print out on the chart they received. Resident #3 is receiving Seroquel for the psychosis, hallucinations and delusions. Resident #3 takes Seroquel on a daily basis and the current usage was evaluated by the resident's attending Physician and our Pharmacist for its clinical need on 7/13/2017. ICD 10 Diagnoses are F33.3 Major Depressive disorder , recurrent,</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135097	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/29/2017
NAME OF PROVIDER OR SUPPLIER ASHTON MEMORIAL LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 700 NORTH SECOND STREET ASHTON, ID 83420		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 329	<p>Continued From page 7</p> <p>25 mg (milligrams) in the morning and 50 mg in the evening beginning 5/29/17 for a diagnosis of major depressive disorder and severe psychotic symptoms; and Cymbalta 30 mg daily in the morning for a diagnosis major depressive disorder, initiated 1/25/17.</p> <p>Resident #1's Psychotropic Medication Care Plan, dated 1/25/17, documented Resident #1 used psychotropic medications for major depression and severe psychotic symptoms. Interventions included:</p> <ul style="list-style-type: none"> * Dim the lights and play relaxing music when Resident #1 becomes overwhelmed. Resident #1 enjoys classic country, Elvis, and Kenny Rogers. * Redirect Resident #1 away from inappropriate behavior by focusing her attention to a low stimulation activity or a 1:1 task. Keep Resident #1 in a safe place from others. * Monitor Resident #1 for behavior symptoms and document on the behavior monitoring sheet and the nurse's notes. The documented behaviors on the care plan were aggression/agitation towards staff and others, over stimulation, and wandering. It was not clear how these behaviors were an indication of either major depressive or severe psychotic symptoms, or were an indication of use for antipsychotic medication. <p>The Behavior/Mood Monitor Sheets, dated May 2017 and June 2017, directed staff to document Resident #1's behaviors for depression. The Behavior/Mood Monitor Sheets identified Resident #1's target behaviors as yelling,</p>	F 329	<p>severe with psychotic features and F03.91 Unspecified Dementia with behavioral disturbances. After their review, it was determined the medication is still needed. The care plan was reviewed and it now more clearly specifies how the resident's psychosis, hallucinations, and delusions present. Also resident-specific interventions are included on the behavior/mood monitor sheets for the staff to monitor to have a positive outcome for resident.</p> <p>Other Residents - All other Residents have potential to be affected.</p> <p>Systemic Changes - An audit was conducted on all Residents for a Drug Regimen to ensure they are free from unnecessary drugs. Any resident who has been identified with psychotropic drugs documentation will be monitored to identify if the medication is necessary to treat a specific condition as diagnosed. ALC is now discussing the residents on Antipsychotics in weekly IDT meeting by reviewing the charting and Dr.'s orders to make sure Drug Regimen is free from unnecessary drugs. A note will be made in patients chart about review. Those residents will be reviewed by pharmacists monthly and recommend gradual dose reductions. IDT will review behavioral interventions in an effort to discontinue these drugs. Training was done with nurses 7/19/2017 about assessing and charting behaviors related to Antipsychotics. All staff training on</p>		

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

PRINTED: 08/02/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135097	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/29/2017
NAME OF PROVIDER OR SUPPLIER ASHTON MEMORIAL LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 700 NORTH SECOND STREET ASHTON, ID 83420		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 329	<p>Continued From page 8</p> <p>confused, refused care, attempting to leave the building, transfer self, isolate herself, and swearing at others. The behaviors documented as target behaviors to be monitored on Resident #1's care plan were not included on the monitoring sheets. The interventions included explaining cares to Resident #1, assisting Resident #1 as needed, asking if Resident #1 was hurting, notifying the LN about Resident #1's behavior, listening to Resident #1, and taking care of basic needs - hunger, thirst, temperature. The sheets did not document the resident-specific interventions as identified in Resident #1's care plan.</p> <p>Resident #1's Behavior/Mood Monitor Sheets for May and June 2017 documented the resident displayed behaviors for all but 4 of 183 shifts. The monitors did not document whether the resident-specific interventions documented on Resident #1's care plan were attempted, or whether they were effective. The effectiveness of the interventions documented on the monitors was "unchanged" for all 179 shifts during which behaviors were documented as present.</p> <p>The Behavior/Mood Monitor Sheet, dated June 2017, documented Resident #1 had experienced behaviors every day and every shift except for 6/1/17 and 6/19/17 on the evening shifts. All interventions were attempted with an "unchanged" outcome.</p> <p>The Behavior/Mood Monitoring Sheets did not include resident-specific target behaviors and interventions to monitor by the facility staff.</p> <p>2. Resident #3 was admitted to the facility on</p>	F 329	<p>7/19/2017 training was done on behavior sheets and how to utilize them in caring for our residents and charting behaviors. Hand in Hand Module was also covered at this training.</p> <p>Monitor - In our weekly IDT meeting, residents with Antipsychotic medication will be discussed and reviewed to identify if the medication is necessary to treat a specific condition as diagnosed. Review will be documented.</p>		

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

PRINTED: 08/02/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135097	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/29/2017
NAME OF PROVIDER OR SUPPLIER ASHTON MEMORIAL LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 700 NORTH SECOND STREET ASHTON, ID 83420		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 329	<p>Continued From page 9</p> <p>8/11/13 with multiple diagnoses, including Alzheimer's disease, anxiety, and major depression.</p> <p>Resident #3's quarterly MDS assessment, dated 5/1/17, documented Resident #3 experienced hallucinations, delusions and minimal depression.</p> <p>The current Physician Order Report, dated 6/14/17, documented Resident #3 was receiving Seroquel 25 mg daily in the evening for a diagnosis of delirium due to known physiological condition, initiated 12/7/16. Resident #3 was receiving Clonazepam 0.5 mg twice a day for a diagnosis of anxiety, initiated 3/10/17.</p> <p>Resident #3's Psychotropic Medication Care Plan, reviewed 5/2/17, documented Resident #3 had diagnoses of "senile psychosis" and depression, for which she used Seroquel and citalopram. Interventions included:</p> <ul style="list-style-type: none"> * Assess and intervene if Resident #3's behavioral symptoms present a danger to herself and/or others. * Monitor Resident #3's behaviors and document on behavior monitoring sheet. <p>The care plan did not specify how Resident #3's psychosis, hallucinations, or delusions presented.</p> <p>Resident #3's Antianxiety Medication Care Plan, dated 9/30/14, documented a "Problem" of Resident anti-anxiety medication use for anxiety, and that the resident was at risk of adverse</p>	F 329			

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

PRINTED: 08/02/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135097	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/29/2017
NAME OF PROVIDER OR SUPPLIER ASHTON MEMORIAL LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 700 NORTH SECOND STREET ASHTON, ID 83420		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 329	<p>Continued From page 10</p> <p>effects of the medication such as drowsiness or over sedation. The goal was documented as the resident would not experience these adverse reactions. The problem did not include documentation of how the resident's anxiety presented, and the goal did not include the resident's goal for managing her anxiety symptoms. The care plan approaches included:</p> <ul style="list-style-type: none"> * Chart behaviors, interventions, and outcomes on the behavior monitoring sheets and in the nurse's notes. Resident-specific behaviors related to antianxiety medication use were not identified. * Offer alternative interventions 1:1 visits, soft music, moving to a quieter environment, or offer activities provided by the facility. <p>The Behavior/Mood Monitor Sheets, dated May 2017 and June 2017, documented Resident #3's target behaviors, for psychosis as refusing care, crying, feeling tired, wandering, attempting to leave the building, taking other resident's things, or anxiety. The interventions included explaining cares to Resident #3, assisting Resident #3 as needed, assessing Resident #3 for pain, notifying the LN about Resident #3's behavior, distracting Resident #3, taking Resident #3 for a walk outside, or helping Resident #3 with basic needs.</p> <p>The resident-specific interventions as documented on Resident #3's care plan were not included as interventions on the Behavior/Mood Monitor sheets.</p> <p>The Behavior/Mood Monitor Sheets for May and June 2017 documented Resident #3 experienced</p>	F 329			

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

PRINTED: 08/02/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135097	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/29/2017
NAME OF PROVIDER OR SUPPLIER ASHTON MEMORIAL LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 700 NORTH SECOND STREET ASHTON, ID 83420		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 329	Continued From page 11 behaviors daily. The listed interventions were attempted by staff, with "unchanged" as the outcome. On 6/28/17 at 10:40 am, the DNS [Director of Nursing] said the behavior/mood monitor sheets did not have resident-specific target behaviors and interventions for Resident #3. The DNS was not able to state how Resident #3's psychosis, hallucinations, or delusions presented. The DNS was unable to state whether the resident's diagnosis of delirium from 12/7/16 had resolved. The facility failed to demonstrate a clinical need for the use of the Seroquel for Resident #3. The facility failed to ensure resident-specific target behaviors and interventions were in place on the behavior/mood monitor sheets for the staff to monitor to have a positive outcome for Resident #1 and Resident #3.	F 329			
F 368 SS=E	483.60(f)(1)-(3) FREQUENCY OF MEALS/SNACKS AT BEDTIME (f) Frequency of Meals (f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. (f)(2) There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span.	F 368		8/3/17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135097	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/29/2017
NAME OF PROVIDER OR SUPPLIER ASHTON MEMORIAL LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 700 NORTH SECOND STREET ASHTON, ID 83420		
(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 368	<p>Continued From page 12</p> <p>(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to offer snacks at bedtime daily for 7 of 9 residents (Residents #1, #2, #3, #5, #8, #9 and #11) reviewed for dietary services. The deficient practice created the potential for harm if residents experienced hunger or weight loss when not offered a bedtime snacks.</p> <p>Findings include:</p> <ol style="list-style-type: none"> On 6/26/17 at 6:33 p.m., Dietary Service Worker (DS) #1 stated that breakfast was served from 6:45 a.m.- 9:00 a.m., lunch was served 11:45 a.m.-12:30 p.m., and dinner was served 4:45 p.m.- 5:30 p.m. The time frame between the evening meal and breakfast could range from 13.25 hours to 15.5 hours. On 6/26/17 at 6:35 p.m., a tray with resident snacks was in a glass-doored refrigerator in the facility kitchen, The snacks were labeled "3P 6/27" and were labeled for Residents #1, #2, #5, and #8. On 6/26/17 at 6:50 p.m., the Certified Dietary Manager (CDM) stated that the tray in the refrigerator was for 3:00 p.m. snacks the next day. The CDM said the kitchen sent out snack trays with specific items labeled for residents who were diabetic or had other special needs. Those items would be labeled for 3:00 p.m. or 8:00 p.m. 	F 368	<p>Specific Residents- Residents #1, #2, #3, #5, #8, #9 and #11 are provided snacks.</p> <p>Other Residents - All other Residents have potential to be affected.</p> <p>Systemic Changes - We have made snacks more readily available. We educated staff in training on 7/19/2017 about the importance of snacks and providing snacks to residents in a way that encourages residents to take a snack. The snack cart will be labeled and in view of residents during snack times to decide so they may choose what snack they want. Dietary Supervisor will provide instruction to CNA's on an individual basis to demonstrate how to provide snacks in an manner that will encourage residents to enjoy a snack.</p> <p>Monitoring - Dietary Supervisor or designee will observe how snacks are being passed, provided at least once weekly for 8 weeks. A sample of the residents will be intermittently interviewed by DNS or designee at least weekly to see if they are being provided snacks. Audits of charting of snacks will be done daily by Dietary Supervisor for 2</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135097	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/29/2017
NAME OF PROVIDER OR SUPPLIER ASHTON MEMORIAL LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 700 NORTH SECOND STREET ASHTON, ID 83420		
(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 368	<p>Continued From page 13</p> <p>The CDM stated that there were a variety of cookies and juices available for other residents at snack times.</p> <p>3. On 6/26/17 at 8:05 pm, CNA #5 stated that normal activities after supper included finishing assigned showers, changing residents, assisting residents to bed, and cleaning up. CNA #5 did not mention passing snacks. Staff were not observed to pass or offer snacks between 8:00 pm and 8:35 pm on 6/26/17.</p> <p>4. On 6/26/17 at 8:35 p.m. CNA #5 stated that Residents #1, # 3, #5, and #8 received snacks at 3:00 p.m., and that more residents received snacks at 8:00 p.m., including Resident #9. CNA #5 stated that snacks were passed between 8:00 p.m. and 9:00 p.m., and that the snacks were in the nurses' station. CNA #5 pointed out a tray of wrapped labeled sandwiches and drinks on the counter. The CNA sated that the snack tray is usually delivered to the refrigerator in the nurses' station by dietary staff, and the staff working the floor pull them out around 8:00 pm to deliver them to the residents. In addition to the labeled snacks, there were two sandwich halves on the tray labeled "extra." CNA #5 stated they give the extras to whoever may ask for them. CNA #5 stated that for those residents without individually labeled snacks, there were unlabeled cookies for those who wanted a snack, and juice was available.</p> <p>5. On 6/26/17 from 8:37 p.m. until 9:00 p.m. staff were not observed passing snacks, and the snack tray remained in the nurses' station. At 9:00 p.m., LN #1 stated that the CNAs deliver the bedtime snacks, but that LN #1 could help with</p>	F 368	<p>weeks then 1x per week for 6 weeks. Reports will be provided to the QAPI committee.</p>		

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

PRINTED: 08/02/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135097	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/29/2017
NAME OF PROVIDER OR SUPPLIER ASHTON MEMORIAL LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 700 NORTH SECOND STREET ASHTON, ID 83420		
(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 368	<p>Continued From page 14</p> <p>delivery. LN #1 stated that she was going to check Resident #2's blood sugar, and would then give Resident #2 her snack, which was typically a half sandwich. LN #1 stated that all residents were asked if they wanted a snack, and diabetics have a prepared labeled snack. LN #1 stated that normally Resident #2 would get her snack between 8:00 p.m. and 9:00 p.m.</p> <p>6. Resident Reviews:</p> <p>a. On 6/27/17 at 3:00 p.m., Resident #11 stated she received a snack in the afternoon but not at bedtime. She stated she did not ask for one at night and they did not offer,</p> <p>Resident #11's 4/5/17 quarterly Minimum Data Set (MDS) dated 4/5/17 documented she was cognitively intact. Her care plan specified to monitor her percentage of food intake, including snacks. Resident #11's "Vitals Report", dated 5/29/17-6/29/17, revealed no bedtime snacks were documented for the recording period.</p> <p>b. On 6/29/17 at 11:25 a.m., Resident #8 stated "no" when asked if she received a snack after supper.</p> <p>Resident #8's "in-process" MDS admission assessment dated 6/27/17 revealed she was cognitively intact. Resident #8's Electronic Health Record (EHR) revealed a nutritional note, dated 6/19/17, that documented she had not eaten well and had a recent 20-pound weight loss</p> <p>Resident #8's "Vitals Report", dated 6/19/17-6/28/17, revealed no bedtime snacks were documented for the recording period.</p>	F 368			

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

PRINTED: 08/02/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135097	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/29/2017
NAME OF PROVIDER OR SUPPLIER ASHTON MEMORIAL LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 700 NORTH SECOND STREET ASHTON, ID 83420		
(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 368	Continued From page 15 c. Resident #1's plan of care, dated 3/23/17, revealed a history of meal refusals and weight loss. The plan specified to monitor the percentage of food intake, including snacks. Resident #1's "Vitals Report", dated 5/28/17-6/28/17, revealed two entries for "Bedtime Snack." On 6/11/17 Resident #1 consumed 76-100 % of a bedtime snack. On 5/30/17 a bedtime snack was not taken due to unavailability. No other bedtime snacks were documented for the recording period. d. Resident #2's care plan, dated 5/18/17, revealed she had a potential for alteration in nutrition related to Alzheimer's. The plan specified to monitor the percentage of food intake, including snacks. Resident #2's "Vitals Report" dated 5/28/17-6/28/17 revealed no bedtime snacks were documented for the recording period. e. Resident #3's care plan, dated 5/11/17, revealed she was to be provided with 3:00 p.m. and 8:00 p.m. snacks. Resident #3's "Vitals Report", dated 5/28/17-6/28/17, revealed eight entries for "Bedtime Snack." On 5/31/17 and on 6/16/17 Resident #3 consumed 76-100 % of a bedtime snack. On 5/30/17 and 6/11/17 a bedtime snack was not taken due to unavailability. Once on 6/26/17 and three times on 6/27/17 a bedtime snack was not taken due to deferred due to condition. No other bedtime snacks were documented for the recording period. f. Similar results were noted for Resident #s 5	F 368			

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

PRINTED: 08/02/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135097	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/29/2017
NAME OF PROVIDER OR SUPPLIER ASHTON MEMORIAL LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 700 NORTH SECOND STREET ASHTON, ID 83420		
(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 368	Continued From page 16 and 9. 7. On 6/29/17 at 1:50 pm, the Director of Nursing Services (DNS), stated that everyone was supposed to get a bedtime snack. The DNS said that snacks may be refused, but they must be offered. The DNS said the CNAs and charge nurses should be monitoring to ensure the snacks are passed, and the nurses should especially watch to ensure diabetics receive their snacks. According to the DNS residents with impaired cognition should be physically shown snack choices to facilitate their acceptance of a snack. 8. An undated facility policy, "Snacks (Between Meal and Bedtime), Serving" revealed the snack was to be place on an overbed table or serving area. The policy further instructed staff to "...arrange so it [snack] can be easily reached and place beverage within easy reach. Record in the resident's record the date and time the snack was offered, who served the snack, the amount of snack eaten, if the resident refused the snack, the reason why and the intervention taken."	F 368			
F 441 SS=F	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 a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals	F 441		8/3/17	

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

PRINTED: 08/02/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135097	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/29/2017
NAME OF PROVIDER OR SUPPLIER ASHTON MEMORIAL LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 700 NORTH SECOND STREET ASHTON, ID 83420		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	<p>Continued From page 17</p> <p>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> <p>(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</p>	F 441			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135097	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/29/2017
NAME OF PROVIDER OR SUPPLIER ASHTON MEMORIAL LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 700 NORTH SECOND STREET ASHTON, ID 83420		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	<p>Continued From page 18</p> <p>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>(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 interview and record review, the facility failed to establish an infection prevention and control program (IPCP) that included a system for collecting and analyzing data to detect potential clusters and trends of infections occurring within the facility. This was true for 9 of 10 sampled residents (#s 1-9), and had the potential to impact all residents in the facility. The deficient practice created the potential for harm if residents were exposed to infections from sources not identified by the facility.</p> <p>Findings include: On 6/27/17 at 2:05 p.m., the DNS stated that he currently served as the Infection Control Preventionist for the facility. The DNS stated the facility's determination of the source of resident infection depended on the resident, as a tenured resident likely acquired an infection in the facility, but a newer resident may have admitted with an</p>	F 441	<p>F441 Specific Residents - No specific Residents Identified.</p> <p>Other Residents - All Residents have potential to be impacted.</p> <p>Systemic Changes - Infection Preventionist is monitoring infections daily and documenting dates, time and location and keeping a log and will map infections in the facility. It will be color coded to specific infections and each infection will be dated by date it was identified or acquired. The DNS and Infection Preventionist will discuss concerns weekly and will bring any concerns to the weekly IDT meeting DNS or Infection Control Designee will collect daily infection data and compile the information from log into a report for infection control</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135097	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/29/2017
NAME OF PROVIDER OR SUPPLIER ASHTON MEMORIAL LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 700 NORTH SECOND STREET ASHTON, ID 83420		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	<p>Continued From page 19</p> <p>infection. The DNS stated he complied a quarterly report which he presented when the infection control committee met in conjunction with Quality Assurance Committee. The DNS stated there were no additional measures in place to investigate how and if infections were acquired within the facility.</p> <p>During the same interview, the DNS provided the facility's infection control binder, which did not include a policy or procedure outlining a program of comprehensive collection of infection related data within the facility; an analysis to track, trend, or map infections so as to suggest possible appropriate preventative interventions to reduce transmission; or current or historical facility-specific infection data or IPCP reports.</p> <p>On 6/28/17 at 1:45 p.m., the Administrator stated that all the nurses maintain active communication about infections in the facility. The Administrator said the Infection Control Committee met quarterly concurrently with the Quality Assurance Committee. According to the Administrator, the DNS currently served as the Infection Control Preventionist, but LN #2 would be transitioning into that role. The Administrator stated the facility did not currently maintain data on antibiotic therapy, and had never done facility mapping of infections. The Administrator stated they might rely too heavily on active nurses and general data because the facility was small and did not have multiple wings. He produced signature sheets from the quarterly meetings, and a one page document "Infection Control Quarterly Report" for three of the four signature sheets, which documented:</p>	F 441	<p>meeting. The specific data used for report will be maintained with report and the infection control committee will determine plan of action if problem is identified. This will allow interdisciplinary team to identify clusters and trends of infections in the building. Facility just had an RN complete the training early June to be Infection Preventionist and will use her expertise to help manage infection control program.</p> <p>Monitor - DNS or Designee will review Infection Preventionist's infection tracking and mapping weekly for 8 weeks to make sure it is being recorded daily. Infections will be monitored by DNS and Infection Preventionist daily and discussed weekly. If an issue is determined it will be brought to IDT to determine exact plan of action. Reports will be made to Infection Control Committee.</p>		

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

PRINTED: 08/02/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135097	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/29/2017
NAME OF PROVIDER OR SUPPLIER ASHTON MEMORIAL LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 700 NORTH SECOND STREET ASHTON, ID 83420		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	<p>Continued From page 20</p> <p>*Staff Meeting Attendance Sheet - Infection Control, QAPI (Quality Assurance Performance Improvement), and Pharmacy dated 12/8/16 revealed the following attached: Infection Control Fourth Quarter 2016. September 2016- 0 infections October 2016- UTI (urinary tract infection) 1- 4% infection rate November 2016- UTI 4- 14 % infection rate</p> <p>*Staff Meeting Attendance Sheet - Infection Control, QAPI, and Pharmacy dated 3/9/17 revealed the following attached: Infection Control First Quarter 2017. December 2016- Skin 1, URI (Upper respiratory Infection) 3, UTI 2- 20% infection rate January 2017- URI 3, UTI 2- 17% infection rate February 2017- UTI 1- 3 % infection rate</p> <p>*Staff Meeting Attendance Sheet - Infection Control, QAPI, and Pharmacy dated 6/15/17 revealed the following attached: Infection Control Second Quarter 2017. March 2017- Skin 1- 4% infection rate April 2017- Eye 1, URI 1, UTI 1- 10% infection rate May 2017- UTI 1- 4% infection rate</p> <p>On 6/28/17 at 2:30 p.m., the DNS stated he did not keep any of the documentation he used to compile the Infection Control reports. The DNS described pulling reports of individual residents with possible infections, and compiling a monthly overview of residents on antibiotic, although he did not keep this information once the Infection Control Quarterly Report was compiled. The DNS stated that the process did not include strategies such as facility mapping of developing infections.</p>	F 441			

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

PRINTED: 08/02/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135097	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/29/2017
NAME OF PROVIDER OR SUPPLIER ASHTON MEMORIAL LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 700 NORTH SECOND STREET ASHTON, ID 83420		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	<p>Continued From page 21</p> <p>The DNS provided a "How To ' Infection Control" document he used to compile his quarterly reports, which documented:</p> <ol style="list-style-type: none"> 1. Every month print out an electronic report of who is on antibiotics. 2. Monitor infections contracted at the facility, and monitor for spread of infections within the facility. 3. Cross out those who were on antibiotics when they came into the facility 4. Cross out any prophylactic antibiotics. 5. Complete an infection control event for each antibiotic remaining on the list, including a note from the culture report that the organism is susceptible to the antibiotic. 6. Count each kind of infection. 7. Using a provided formula, calculate to get the percent of residents in the month that had an infection starting that month. <p>The document did not describe the process for how to monitor for the spread of infections within the facility.</p> <p>During an interview on 6/28/17 at 2:50 p.m., the Administrator provided an undated "Operational Policy and Procedural Manual- Committees." It documented that the Infection Control Committee would maintain minutes that contained the date and time of the meeting, findings, recommendations, and it documented that duties of the Infection Control Committee included developing written policies and procedures for the investigation, prevention, and control of infectious or communicable diseases within the facility. Duties also included developing written policies and procedures for the technique and systems used to identify infections within the</p>	F 441			

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

PRINTED: 08/02/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135097	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/29/2017
NAME OF PROVIDER OR SUPPLIER ASHTON MEMORIAL LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 700 NORTH SECOND STREET ASHTON, ID 83420		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	Continued From page 22 facility.	F 441			

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001010	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/29/2017
--	--	---	---

NAME OF PROVIDER OR SUPPLIER ASHTON MEMORIAL LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 700 NORTH SECOND STREET ASHTON, ID 83420
--	--

(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 on June 26, 2017 to June 29, 2017.</p> <p>The surveyors conducting the survey were:</p> <p>Jenny Walker, RN, Team Coordinator Melanie Tatom, RN</p>	C 000		
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 review of Quality Assurance Performance Improvement meeting minutes and staff interview, it was determined the facility failed to ensure the Administrator, Maintenance and Housekeeping managers participated in the facility's Infection Control Meetings at least quarterly. This failure created the potential for negative outcomes for residents, visitors, and staff in the facility related to the prevention of infections and disease. Findings included:</p> <p>On 6/29/17 at 3:30 pm, the Infection Control Meeting Attendance Sheet was reviewed with the Administrator. The Administrator said the facility held its Quality Assurance Performance Improvement meetings on a quarterly basis and infection control was a component of those meetings.</p> <p>The Administrator provided attendance records,</p>	C 664	<p>Specific Residents - No specific Residents Identified.</p> <p>Other Residents - All Residents have potential to be impacted.</p> <p>Systemic Changes - All staff on infection control committee or designee will participate in infection control meetings at a minimum of quarterly. Meeting will be scheduled at a time that all can attend and their signature will be on the meeting attendance form to show they are in attendance.</p> <p>Monitor - Administrator will monitor attendance of Infection control meetings to assure all departments are represented.</p>	8/3/17

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

TITLE

(X6) DATE
07/21/17

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001010	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/29/2017
--	--	---	---

NAME OF PROVIDER OR SUPPLIER ASHTON MEMORIAL LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 700 NORTH SECOND STREET ASHTON, ID 83420
--	--

(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 664	Continued From page 1 dated 9/15/16, 12/8/16, 3/9/17, and 6/15/17, documented the Maintenance Manager failed to attend the Infection Control Meetings. The Administrator failed to attend the Infection Control Meetings on 12/8/16 and 3/9/17. The Housekeeping Manager failed to attend the Infection Control Meeting on 6/15/17.	C 664		