



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RUSSELL S. 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
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May 25, 2018

Dallas Clinger, Administrator
Power County Nursing Home
PO Box 420
American Falls, ID 83211-0420

Provider #: 135066

Dear Mr. Clinger:

On **May 17, 2018**, a survey was conducted at Power County Nursing Home 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.) **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.

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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 **June 4, 2018**. Failure to submit an acceptable PoC by **June 4, 2018**, may result in the imposition of additional civil monetary penalties by **June 27, 2018**.

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.
- 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*.

This agency is required to notify Centers for Medicare & Medicaid Services (CMS) Regional Office of the results of this survey. We are recommending to the CMS Regional Office that the following remedy(ies) be imposed:

- Denial of Payment for New Admission on or after August 17, 2018

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **November 17, 2018**, 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 and Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

Your facility's noncompliance with the following:

- **F0883 -- S/S: F -- 483.80(d)(1)(2) -- Influenza And Pneumococcal Immunizations**

has been determined to constitute substandard quality of care (SQC) as defined at 42 CFR §488.301. Sections 1819 (g)(5)(c) and 1919 (g)(5)(c) of the Social Security Act and 42 CFR §488.325 (h) requires the attending physician of each resident who was found to have received substandard quality of care, as well as the state board responsible for licensing the facility's administrator be notified of the substandard quality of care. In order for us to satisfy these notification requirements, and in accordance with 42 CFR §488.325(g), you are required to provide the following information to this agency within ten (10) working days of your receipt of this letter:

The name and address of the attending physician of each resident found to have received substandard quality of care, as identified below:

Residents # **#2, #5, #6, #9, #12** as identified on the enclosed Resident Identifier List.

Please note that in accordance with 42 CFR §488.325(g), your failure to provide this information timely will result in termination of participation or imposition of additional remedies.

If you believe the deficiencies have been corrected, you may contact Debby Ransom, RN, RHIT, Bureau Chief, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 5; 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.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You may also contest scope and severity assessments for deficiencies, which resulted in a finding of SQC or immediate jeopardy. To be given such an opportunity, you are required to send your written request and all required

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information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

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

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

- BFS Letters (06/30/11)

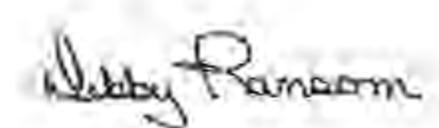
2001-10 Long Term Care Informal Dispute Resolution Process

2001-10 IDR Request Form

This request must be received by **June 4, 2018** . If your request for informal dispute resolution is received after **June 4, 2018**, 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 Debby Ransom, RN, RHIT, Bureau Chief at (208) 334-6626, option 5.

Sincerely,



Debby Ransom, RN, RHIT, Chief
Bureau of Facility Standards

DR/lj

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

PRINTED: 06/13/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135066	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/17/2018
NAME OF PROVIDER OR SUPPLIER POWER COUNTY NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 510 ROOSEVELT STREET (83211-1362) AMERICAN FALLS, ID 83211		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS The following deficiencies were cited during the federal recertification survey conducted at the facility from May 14, 2018 through May 17, 2018. The surveyors conducting the survey were: Edith Cecil RN, Team Coordinator Jenny Walker, RN Abbreviations: BG = blood glucose CDC = Centers for Disease Control and Prevention COPD = Chronic Obstructive Pulmonary Disease DNS = Director of Nursing MDS = Minimum Data Set LPN = Licensed Practical Nurse NS= Nursing Student mg = milligram	F 000			
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure residents' assessments accurately reflected hospice services. This was true for 1 of 11 (#15) sampled residents were reviewed for MDS assessment accuracy. This failure had the potential for harm if Resident #15's care plan was inaccurate and specific needs were not met.	F 641	F641 SS=D 483.20(g) ACCURACY OF ASSESSMENTS What corrective actions will be accomplished for those residents found to be affected by the deficient practice. Resident (#15) was found to have 3 MDS assessments submitted that were	6/7/18	

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

TITLE

(X6) DATE

Electronically Signed

06/04/2018

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 641	<p>Continued From page 1</p> <p>Findings include:</p> <p>Resident #15 was admitted to the facility on 12/5/16 with multiple diagnoses, including hospice care for COPD.</p> <p>The admission MDS assessment, dated 12/16/16, documented Resident #15 received hospice care.</p> <p>A quarterly MDS assessment, dated 3/20/17, documented Resident #15 did not receive hospice care.</p> <p>The annual MDS assessment, dated 12/19/17, documented Resident #15 did not receive hospice care.</p> <p>A quarterly MDS assessment, dated 3/21/18, documented Resident #15 did not receive hospice care.</p> <p>Resident #15's care plan, target date 6/13/18, documented Resident #15 was receiving hospice services, initiated 12/18/16.</p> <p>On 5/14/18 at 1:30 PM, a hospice nurse was observed assessing Resident #15.</p> <p>On 5/17/18 at 9:30 AM, the DNS stated Resident #15 received hospice services since she was admitted to the facility on 12/5/16. The DNS stated the MDS assessments for Resident #15 should have documented she received hospice services.</p>	F 641	<p>erroneously documented as not on hospice. The MDS Coordinator corrected the 3 assessments and re-submitted to CMS on 5/30/18. The MDS Coordinator also contacted the billing office to alert them of error.</p> <p>How will you identify other resident(s) having the potential to be affected and what corrective action(s) will be taken. Any resident on hospice has the potential to be affected. The MDS Coordinator reviewed the current resident census list and no other current residents are utilizing hospice services that would affect MDS submissions. The MDS Coordinator also reviewed all hospice residents that were in the facility in the last year on 5/31/18 to check their corresponding MDS submissions. There were 3 residents with hospice services and all 3 were coded correctly for hospice on their MDS submissions.</p> <p>What measures will be put in place to ensure that the deficient practice does not recur. The MDS Coordinator has added hospice services to the facility MDS checklist to remind the Coordinator to ensure that hospice care is marked for applicable residents when submitting future MDS information.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur. The MDS Coordinator will use the</p>		

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F 641	Continued From page 2	F 641	updated checklist to verify all MDS submissions for compliance with documentation, beginning 6/4/18 and hereafter for all MDS submissions; the DON Assistant will also double check the MDS documentation and checklist before MDS submission to review with the MDS Coordinator and RN if necessary for corrections and clarification. Any discrepancies will be reported to the QAPI Committee and Administrator for follow-up.		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR	F 656		6/4/18	

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F 656	<p>Continued From page 3</p> <p>recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.</p> <p>(iv) In consultation with the resident and the resident's representative(s)-</p> <p>(A) The resident's goals for admission and desired outcomes.</p> <p>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.</p> <p>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, policy review, and staff interview, it was determined the facility failed to develop and implement comprehensive resident-centered care plans related to the use of psychotropic medications. This was true for 4 of 6 residents (#7, #10, #13, and #15) reviewed for psychotropic medications. The residents' care plans did not address the use of psychotropic medications, including identification of resident specific behaviors to monitor, behavioral goals, or interventions to address behaviors exhibited. This failure created the potential for harm if residents experienced continued anxiety, depression, or a deterioration in mental health status. Findings include:</p> <p>1. Resident #7 was admitted to the facility on 8/10/17 with diagnoses of Alzheimer's dementia and dementia with behavioral disturbance.</p>	F 656	<p>F656 SS= E 483.21(b)(1) DEVELOP/IMPLEMENT COMPREHENSIVE CARE PLAN</p> <p>What corrective actions will be accomplished for those residents found to be affected by the deficient practice. On 5/31/18 an audit of care plans for all residents was performed. All care plans were updated to reflect all residents receiving psychotropic medications or with a history of behaviors. The updates reflected specific behaviors being monitored in the MAR. Measurable goals were updated on all residents with behavior monitoring. Personalized interventions were added to each care plan that reflects the interventions being applied and tracked in the MAR.</p>		

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F 656	<p>Continued From page 4</p> <p>Resident #7's physician orders for May 2018, included olanzapine (antipsychotic) 15 mg by mouth at bedtime for agitation, Trazodone (antidepressant) 50 mg at bedtime for depression and sleep, Fluoxetine (antidepressant) 10 mg by mouth daily for mood stabilization, and clonazepam (tranquilizer) 0.5 mg at bedtime for agitation.</p> <p>A quarterly MDS assessment dated 2/23/18, documented Resident #7 received antipsychotic, antidepressant, and hypnotic medications daily.</p> <p>A Care Plan dated 8/11/17, documented Resident #7 received psychotropic medications related to her diagnoses and behavioral symptoms. The care plan did not include resident-specific behaviors staff were to monitor, directions for staff to record Resident #7's hours of sleep, and interventions staff were to implemented when she exhibited behavioral symptoms.</p> <p>On 5/17/18 at 10:55 AM, the DNS stated the care plan was not comprehensive and did not address psychotropic medications, resident-specific target behaviors, and behavioral interventions.</p> <p>2. Resident #10 was admitted to the facility on 2/26/14 with multiple diagnoses that included cerebrovascular disease, chronic obstructive pulmonary disease, and pain.</p> <p>Resident #10's physician orders for May 2018, included Trazodone 50 mg by mouth at bedtime for insomnia and depression.</p>	F 656	<p>On 5/18/18, a daily behavior sheet for day and night shift staff was added to document behaviors, number of occurrences, interventions, and efficacy which have been placed in the MAR for all residents on psychotropic medication or with a history of behaviors. We will no longer be charting behaviors only as they occur. The LSW will continue to review documentation in preparation for pharmacy review monthly.</p> <p>1. On 5/18/18 a behavior monitor for Resident #7 was placed in the MAR to track behaviors and interventions on a daily basis. On 5/30/18, Resident #7 care plan was updated to reflect the use of psychotropic medications coinciding with behaviors she generally exhibits such as wandering and false beliefs, as well as a goal of less than 1 behavior daily. We added specific interventions to her care plan such as 1-1 and watching her spouse video. These behaviors and interventions were compared with behavior monitoring sheets in MAR for continuity.</p> <p>2. On 5/30/18 physician documentation was received on Resident #10 clarifying the physician diagnosis as insomnia. On 5/18/18 a behavior monitor for Resident #10 was placed in the MAR to track behaviors and interventions on a daily basis. On 5/31/18, Resident #10 care plan was updated to reflect behaviors he generally exhibits such as false beliefs, verbal aggression, and sexual aggression with a behavior goal of one or less</p>		

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F 656	<p>Continued From page 5</p> <p>A quarterly MDS assessment, dated 3/9/18, documented Resident #10 received antidepressant medications daily.</p> <p>A Care Plan dated 8/24/16, documented Resident #10 had the potential to be verbally aggressive by calling staff insulting names, and could make sexually inappropriate comments. The care plan did not address the specific reason the antidepressant medication was prescribed, direct staff to monitor Resident #10's hours of sleep, or include interventions staff were to implement when he exhibited behaviors.</p> <p>On 5/17/18 at 10:55 AM, the DNS stated the care plan was not comprehensive and did not address medications, resident-specific target behaviors, and interventions.</p> <p>3. Resident #13 was admitted to the facility on 8/31/17 with diagnoses that included cerebral infarction (stroke) with cognitive social or emotional deficit.</p> <p>Resident #13's physician orders for May 2018, included Effexor XR (antidepressant-extended release) 225 mg daily in the AM for depression, Seroquel (antipsychotic) 150 mg each AM and 100 mg in the PM for agitation and behaviors, clonazepam 1 mg twice daily for anxiety, and Trazodone 50 mg at bedtime for insomnia.</p> <p>A quarterly MDS assessment, dated 3/16/18, documented Resident #13 received antipsychotic, antidepressant, antianxiety, and hypnotic medications daily.</p> <p>A Care Plan dated 9/6/17, documented Resident</p>	F 656	<p>behaviors a day added. Personalized interventions were added such as offering to go to the store and staff making an effort to provide care in a way to minimize contact. In addition, his care plan was changed to reflect that he is on psychotropic medication with a diagnosis of insomnia and he displays behaviors of insomnia and turning up his TV loudly at night disturbing other residents sleep with a behavior goal of two or less behaviors a week added related to the insomnia. Interventions such as sleep monitoring, providing music and memory, and prompting the resident to turn down his TV volume were added. These behaviors and interventions were compared with behavior monitoring sheets in MAR for continuity.</p> <p>3. On 5/18/18 a behavior monitor for Resident #13 was placed in the MAR to track behaviors and interventions on a daily basis. On 5/31/18, Resident #13 care plan was updated to reflect the use of psychotropic medications coinciding with behaviors she generally exhibits such as repetitive disruptive yelling, physical aggression, and verbal aggression. A behavior goal of 10 or less behaviors a day was added. Personalized interventions were added such as offering picture books or providing manipulative/fidget objects. In addition sleep monitoring was added to the care plan. These behaviors and interventions were compared with behavior monitoring sheets in MAR for continuity.</p>		

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F 656	<p>Continued From page 6</p> <p>#13 received psychotropic medications due to behavior problems and a goal that she would have no adverse side effects from the medication therapy. The care plan did not include resident-specific behaviors to monitor and document, and interventions staff were to implement in response to Resident #13's behaviors.</p> <p>On 5/17/18 at 10:55 AM, the DNS stated the care plan did not address resident-specific target behaviors related to the use of the medications and interventions staff were to implement.</p> <p>4. Resident #15 was admitted to the facility on 12/5/16 with multiple diagnoses, including COPD.</p> <p>The quarterly MDS assessment, dated 3/21/18, documented Resident #15 was severely cognitively impaired with no signs or symptoms of depression and did not experience behaviors.</p> <p>May 2018 Physician Orders documented Resident #15 received: * 250 mg of Depakote (anticonvulsant) twice a day for aggressive behaviors, dated 4/18/17 * Ativan 0.5 mg at bedtime for anxiety, dated 6/9/17 * Lexapro (antidepressant) 10 mg daily for depression, dated 2/10/17.</p> <p>Resident #15's care plan, revised 10/26/17, documented Resident #15 had a history of anxiety and agitation and received two psychotropic medications. The care plan interventions directed staff to document all behaviors. The care plan did not include resident-specific target behaviors to monitor in</p>	F 656	<p>4. On 5/18/18 a behavior monitor for Resident #15 was placed in the MAR to track behaviors and interventions on a daily basis. On 5/22/18, Resident #15 was discharged from facility and transferred to an Assisted Living Facility by the family, so no further corrective actions were able to be applied to this resident.</p> <p>How will you identify other resident(s) having the potential to be affected and what corrective action(s) will be taken. All residents taking psychotropic medications or with a history of behaviors have potential to be affected. All current resident care plans have been updated to reflect more comprehensive documentation of behaviors. The LSW will review behaviors and interventions monthly during pharmacy review for discussion to determine effectiveness of current interventions and will make changes as needed. Any changes will be updated on both behavior sheets and care plan for continuity and a more comprehensive care plan.</p> <p>What measures will be put in place to ensure that the deficient practice does not recur. For any resident on a psychotropic medication or with a history of behaviors; a generalized behavior monitor form will be initiated on admission. Within five days of admission and IDT meeting will be held to discuss individualized behaviors, goals, and interventions.</p>		

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F 656	Continued From page 7 relation to the use of the medications. On 5/17/18 at 9:30 AM, the DNS stated Resident #15's care plan did not include resident-specific target behaviors to monitor.	F 656	Within 7 days the behavior monitor form and care plan will be updated to reflect the individualized behaviors, goals, and interventions. Behaviors and interventions will then continue to be addressed for care plan changes at the monthly pharmacy review meeting. How the corrective action(s) will be monitored to ensure the deficient practice will not recur. The DON has added auditing behavior monitors for completion to her monthly check list. Beginning 6/4/18, the LSW will also complete a chart audit of resident care plans and compare them to behavior monitors form once a week for two months, and then once a month during pharmacy review. Any discrepancies will be reported to the DON for follow-up.		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility failed to ensure professional standards of practice were followed for 1 of 2 residents (#6) reviewed for falls. A	F 684	F684 SS= D 483.25 QUALITY OF CARE What corrective actions will be	6/4/18	

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F 684	<p>Continued From page 8</p> <p>neurological assessment was not initiated after Resident #6 experienced an unwitnessed fall to the floor. This failed practice had the potential to for Resident #6 to experience undetected adverse neurological changes. Findings include:</p> <p>1. Resident #6 was admitted to the facility on 4/13/18 with multiple diagnoses, including dementia.</p> <p>The admission MDS assessment, dated 4/26/18, documented Resident #6 was severely cognitively impaired and a high risk for falls.</p> <p>An Incident Report Form, dated 4/14/18, documented Resident #6 had an unwitnessed fall in her room. The form documented Resident #6 was found on the floor next to a recliner. A neurological assessment was not initiated.</p> <p>On 5/16/18 at 2:38 PM, the DNS was unable to provide a neurological assessment for Resident #6's unwitnessed fall. The DNS stated with an unwitnessed fall, a neurological assessment should have been initiated. The DNS provided a Fall Prevention Policy and Procedure, dated 6/17/13. The policy did not direct staff to initiate neurological assessments following unwitnessed falls.</p>	F 684	<p>accomplished for those residents found to be affected by the deficient practice. We updated our QMM form on 5/30/18 with the notation to start neuro checks when a fall is unwitnessed as a reminder for staff to complete this and document. The DON also posted a notice for staff and emailed all staff on 5/30/18 with a read-receipt as a reminder to do the neuro checks and document for unwitnessed falls. This will also be re-addressed at the 6/27/18 staff meeting.</p> <p>How will you identify other resident(s) having the potential to be affected and what corrective action(s) will be taken. Any residents who have the potential to fall are at risk. Staff will utilize the updated QMM forms as a reminder to complete neuro checks and documentation for any future resident falls to ensure that potential adverse reactions are identified and treated.</p> <p>What measures will be put in place to ensure that the deficient practice does not recur. Staff will utilize the updated QMM form and staff has been instructed and will be reminded to contact the DON anytime there is a fall so that follow-up can be done on the neuro check compliance and safety of the resident.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur. The DON will use a monitoring sheet to</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 684	Continued From page 9	F 684	check for any resident falls and make sure neuro checks were appropriately done; staffs that are not in compliance will receive a warning write-up. This audit will begin 6/4/18 and will be done weekly for 2 months, then monthly thereafter for 1 year. Any discrepancies will be reported to the QAPI Committee for follow-up.		
F 757 SS=E	<p>Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6)</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>§483.45(d)(1) In excessive dose (including duplicate drug therapy); or</p> <p>§483.45(d)(2) For excessive duration; or</p> <p>§483.45(d)(3) Without adequate monitoring; or</p> <p>§483.45(d)(4) Without adequate indications for its use; or</p> <p>§483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or</p> <p>§483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure residents receiving psychoactive medication had</p>	F 757	F757 SS= E 483.45(d)(1)-(6) UNNECESSARY DRUGS	6/30/18	

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F 757	<p>Continued From page 10</p> <p>a) consents in place prior to initiation of the medications, and b) specific target behaviors identified and monitored. This was true for 6 of 6 (# 5, #6, #7, #10, #13, and #15) sampled residents who received psychoactive medications. These deficient practices created the potential for harm if residents received medications that may result in negative outcomes without clear indication of need, monitoring, or consent. Findings include:</p> <p>1. Resident #7 was admitted to the facility on 8/10/17 with diagnoses of Alzheimer's dementia and dementia with behavioral disturbance.</p> <p>A quarterly MDS assessment dated 2/23/18, documented Resident #7 had severe cognitive impairment, no depression and did not experience hallucinations, delusions, or behaviors. The MDS assessment documented Resident #7 received antipsychotic, antidepressant, and hypnotic medications daily.</p> <p>Resident #7's physician orders for May 2018, included olanzapine (antipsychotic) 15 mg by mouth at bedtime for agitation, Trazodone (antidepressant) 50 mg at bedtime for depression and sleep, Fluoxetine (antidepressant) 10 mg by mouth daily for mood stabilization, and clonazepam (tranquilizer) 0.5 mg at bedtime for agitation.</p> <p>A Care Plan dated 8/11/17, documented Resident #7 received psychotropic medications related to her diagnoses and behavioral symptoms. The care plan did not include resident-specific behaviors staff were to monitor, directions for staff to record Resident #7's hours</p>	F 757	<p>What corrective actions will be accomplished for those residents found to be affected by the deficient practice. On 5/18/18 an audit of all resident's charts was performed. All consent to treat with psychotropic medications was reviewed to compare with residents medications list. Any residents with inaccurate consent to treat with psychotropic medications that needed updated were identified and residents or their representative were contacted to update the consent.</p> <p>1. More information was added to Resident #7 behavior care plan. The behaviors she generally exhibits were added such as wandering and false beliefs, as well as a goal of less than 1 behavior daily. We added specific interventions to her care plan such as 1-1 and watching her spouse video.</p> <p>2. On 5/30/18 physician documentation was received on Resident #10 clarifying the physician diagnosis as insomnia. On 5/18/18 a behavior monitor for Resident #10 was placed in the MAR to track behaviors and interventions on a daily basis. On 5/31/18, Resident #10 care plan was updated to reflect behaviors he generally exhibits such as false beliefs, verbal aggression, and sexual aggression with a behavior goal of one or less behaviors a day added. Personalized interventions were added such as offering to go to the store and staff making an effort to provide care in a way to minimize contact. In addition, his care plan was changed to reflect that he is on</p>		

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F 757	<p>Continued From page 11</p> <p>of sleep, and interventions staff were to implement when she exhibited behavioral symptoms.</p> <p>A monthly Psychotropic Tracking form, dated 4/2018, documented Resident #7 had 13 episodes of confusion, restlessness, and wandering behaviors and 1 episode of repetitive movement. The Psychotropic Tracking form listed interventions as offer activities, 1:1, decrease stimulation, educate, distract, sit by nurse's station, etc.</p> <p>A Daily Sleep Monitoring form, dated 4/2018, documented an "S" when Resident #10 was sleeping and an "A" when the Resident was awake. The documentation was to be completed every hour.</p> <p>The clinical record for Resident #7 did not include assessments, monitoring, clinical indication of use, and evaluations of medication efficacy.</p> <p>On 5/15/18 at 3:45 PM, the LSW and the DNS stated resident behaviors were documented per episode, not daily. The LSW stated she reviewed the nursing documentation for behaviors.</p> <p>2. Resident #10 was admitted to the facility on 2/26/14 with multiple diagnoses that included cerebrovascular disease, chronic obstructive pulmonary disease, and pain.</p> <p>A quarterly MDS assessment, dated 3/9/18, documented Resident #10 had moderate cognitive impairment, no depression and did not experience hallucinations, delusions, or</p>	F 757	<p>psychotropic medication with a diagnosis of insomnia and he displays behaviors of insomnia and turning up his TV loudly at night disturbing other residents sleep with a behavior goal of two or less behaviors a week added related to the insomnia. Interventions such as sleep monitoring, providing music and memory, and prompting the resident to turn down his TV volume were added. These behaviors and interventions were compared with behavior monitoring sheets in MAR for continuity.</p> <p>3. On 5/18/18 a behavior monitor for Resident #13 was placed in the MAR to track behaviors and interventions on a daily basis. On 5/31/18 Resident #13 care plan was updated to reflect the use of psychotropic medications coinciding with behaviors she generally exhibits such as repetitive disruptive yelling, physical aggression, and verbal aggression. A behavior goal of 10 or less behaviors a day was added. Personalized interventions were added such as offer picture books or providing manipulative/fidget objects. In addition sleep monitoring was added to the care plan. These behaviors and interventions were compared with behavior monitoring sheets in MAR for continuity.</p> <p>4. On 5/18/18 a behavior monitor for Resident #5 was placed in the MAR to track behaviors and interventions on a daily basis. On 5/31/18 Resident #5 care plan was updated to reflect the use of psychotropic medications coinciding with behaviors she generally exhibits such as</p>		

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F 757	<p>Continued From page 12 behaviors. The MDS documented Resident #10 received antidepressant medication daily.</p> <p>Resident #10's physician orders for May 2018, included Trazodone 50 mg by mouth at bedtime for insomnia and depression.</p> <p>A Care Plan dated 8/24/16, documented Resident #10 had the potential to be verbally aggressive by calling staff insulting names, and could make sexually inappropriate comments. The care plan directed staff to monitor behaviors daily, document observed behavior and attempted interventions. The care plan did not address the specific reason the antidepressant medication was prescribed. The care plan did not direct staff to monitor Resident #10's hours of sleep, include interventions staff were to implement when the resident exhibited behaviors, or include resident specific signs of depression staff were to monitor for.</p> <p>A monthly Psychotropic Tracking form, dated 4/2018, documented Resident #10 had 4 episodes of confusion, 1 episode of verbal aggression, and 1 episode of sexual inappropriateness. The Psychotropic Tracking form listed interventions for staff to perform cares with another staff present, to redirect, to state boundaries, offer music, etc.</p> <p>A Daily Sleep Monitoring form, dated 4/2018, documented an "S" when Resident #10 was sleeping and an "A" when the Resident was awake. The documentation was to be completed every hour.</p> <p>Resident #10's clinical record did not include</p>	F 757	<p>continuous crying, depression/withdrawn, and expressing false beliefs. A behavior goal of 1 or less behaviors a day was added. Personalized interventions were added such as offering music and memory through a speaker and offer puzzles/games on Ipad. These behaviors and interventions were compared with behavior monitoring sheets in MAR for continuity. On 5/22/18 an updated consent to treat with psychotropic medications was signed and placed in chart.</p> <p>5. On 5/18/18 a behavior monitor for Resident #6 was placed in the MAR to track behaviors and interventions on a daily basis. On 5/31/18 Resident #6 care plan was updated to reflect the use of psychotropic medications coinciding with behaviors she generally exhibits such as depression/withdrawn, refusing medications, refusing food/diminished appetite. A behavior goal of 1 or less behaviors a day was added. Personalized interventions were added such as offering music and memory on low volume and encouraging interaction with my cat. These behaviors and interventions were compared with behavior monitoring sheets in MAR for continuity.</p> <p>6. On 5/18/18 a behavior monitor for Resident #15 was placed in the MAR to track behaviors and interventions on a daily basis. On 5/22/18, Resident #15 was discharged from facility so no further corrective actions were able to be applied to this resident.</p>		

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F 757	<p>Continued From page 13</p> <p>assessments, monitoring, clinical indication of use, and evaluations of the efficacy of the use of the Trazodone.</p> <p>On 5/15/18 at 3:45 PM, the LSW and the DNS stated resident behaviors were documented per episode, not daily. The LSW stated she reviewed the nursing documentation for behaviors.</p> <p>3. Resident #13 was admitted to the facility on 8/31/17 with diagnoses that included senile dementia, and cerebral infarction with cognitive social or emotional deficit.</p> <p>A quarterly MDS assessment, dated 3/16/18, documented Resident #13 had severe cognitive impairment, mild depression and did not experience hallucinations or delusions. The MDS assessment documented Resident #13 exhibited verbal behaviors on one day. The MDS documented Resident #13 received antipsychotic, antidepressant, antianxiety, and hypnotic medications daily.</p> <p>Resident #13's physician orders for May 2018, included Effexor XR (antidepressant-extended release) 225 mg daily in the AM for depression, Seroquel (antipsychotic) 150 mg each AM and 100 mg in the PM for agitation and behaviors, clonazepam 1 mg twice daily for anxiety, and Trazodone 50 mg at bedtime for insomnia.</p> <p>A Care Plan dated 9/6/17, documented Resident #13 received psychotropic medications due to behavior problems and a goal that she would have no adverse side effects from the medication therapy. There were no interventions</p>	F 757	<p>How will you identify other resident(s) having the potential to be affected and what corrective action(s) will be taken. All residents taking psychotropic medications have potential to be affected. Staff will no longer be charting behaviors only as they occur. A new daily behavior sheet added 5/18/18, will help outline steps for all staff shifts to utilize documenting more details related to resident behaviors in the future and review of the behaviors and medications at Pharmacy Review Committee.</p> <p>What measures will be put in place to ensure that the deficient practice does not recur. For any resident on a psychotropic medication or with a history of behaviors; a generalized behavior monitor will be initiated on admission. Within five days of admission an IDT meeting will be held to discuss individualized behaviors, goals, and interventions. Within seven days of the meeting, the behavior monitor and care plan will be updated to reflect the individualized behaviors, goals, and interventions. The LSW will also initiate a checklist during pharmacy review if any medication changes are identified. This checklist will include updating consents with the resident or family to treat with psychotropic medications quarterly. The DON will also review the consents at the monthly Pharmacy Review meeting for compliance. The DON had emailed the other RN</p>		

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F 757	<p>Continued From page 14</p> <p>documented. The care plan did not include resident-specific behaviors to monitor and document, and interventions staff were to implement in response to Resident #13's behaviors.</p> <p>A monthly Psychotropic Tracking form, dated 4/2018, documented Resident #13 had 1 episode of physical aggression, 8 episodes of verbal aggression, 2 episodes of abusive language, and 2 episodes of yelling. The Psychotropic Tracking form listed interventions as frequent encouragement, activities, redirect, reorient, and move from common area.</p> <p>On 5/15/18 at 3:30 PM, the DNS stated Resident #13's record should include documentation of her hours of sleep, but after looking, the DNS stated she did not find it.</p> <p>Resident #13's clinical record did not include assessments, monitoring, clinical indication of use, and evaluations of efficacy of the use of the medications.</p> <p>On 5/15/18 at 3:45 PM, the LSW and the DNS stated resident behaviors were documented per episode, not daily. The LSW stated she reviewed the nursing documentation for behaviors.</p> <p>4. Resident #5 was admitted to the facility on 2/14/18 with multiple diagnoses, including depression.</p> <p>A quarterly MDS assessment, dated 4/12/18, documented Resident #5 was moderately cognitively impaired with minimal depression and</p>	F 757	<p>nursing staff and physicians in January and February 2018 to remind and educate them about psychotropic medication orders, behavior charting, and our policies. The DON will also re-review the psychotropic medication regulations and behavior charting in more details with all nursing staff at the upcoming 6/27/18 staff meeting for continued education, compliance and questions with orders and resident care. Psychotropic medication use and monitoring was added to our new employee checklist.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur.</p> <p>Beginning 6/4/18, the DON will audit the behavior monitor for completion with the monthly checklist for compliance with documentation. This audit will be done weekly for eight weeks, then monthly thereafter. Audit findings and discrepancies will be addressed by the DON with staff and reported at the Pharmacy Review Committee.</p> <p>Beginning 6/4/18, the LSW will perform a chart audit of consent forms to treat with psychotropic medications once a week for two months and then once a month for 3 months. The LSW will also review the consents to treat with psychotropic medications quarterly with resident/residents representative. Audit findings and discrepancies will be reported to the DON for follow-up.</p>		

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F 757	<p>Continued From page 15</p> <p>did not experience hallucinations, delusions, or behaviors.</p> <p>Resident #5's care plan, dated 4/12/18, documented Resident #5 was on a psychotropic medication for depression and included a goal stating "Will have no ASE (adverse side effects) from my psychotropic med use through the next quarter. Interventions directed staff as follows:</p> <ul style="list-style-type: none"> * "Pharmacy review monthly to assess for psychotropic needs." * "quarterly mood assessment by social services." * "Reductions periodically per state regulations and per Dr. advise." <p>The care plan did not identify resident-specific signs and symptoms of depression for staff to monitor.</p> <p>The current Physician Orders, dated 4/12/18, documented Resident #5 received Cymbalta (antidepressant) 30 mg daily for depression, ordered 2/14/18.</p> <p>A Physician Order, dated 4/25/18, documented Resident #5 started Lexapro 10 mg daily for depression.</p> <p>Resident #5's clinical record did not include assessments, monitoring, clinical indication of use, and evaluations of medication efficacy. Resident #5's clinical record did not include a consent for the use of Lexapro.</p> <p>On 5/16/18 12:02 PM, the DNS stated Resident #5 did not have a consent for the Lexapro. The</p>	F 757			

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F 757	<p>Continued From page 16</p> <p>DNS stated was unable to provide documentation of the indications for the use of Lexapro. The DNS stated Resident #5's clinical record did not include daily monitoring of resident specific target behaviors related to depression.</p> <p>5. Resident #6 was admitted to the facility on 4/13/18 with multiple diagnoses, including depression.</p> <p>The admission MDS assessment, dated 4/26/18, documented Resident #6 was severely cognitively impaired and had no signs or symptoms of depression.</p> <p>Resident #6's care plan, dated 4/30/18, documented Resident #6 was at risk for depression related to placement in the facility. The care plan goals documented, "Will show no signs of depression or sadness through the next quarter." Interventions documented, "Document any signs of sadness, weeping or negative statements."</p> <p>An Admission Order, dated 4/13/18, documented Resident #6 received Zoloft (antidepressant) 50 mg daily for depression.</p> <p>Resident #6's clinical record did not include assessment, monitoring, and evaluation of the efficacy of the Zoloft.</p> <p>On 5/16/18 at 3:05 PM, the DNS stated the staff did not monitor Resident #6's depression.</p> <p>6. Resident #15 was admitted to the facility on 12/5/16 with multiple diagnoses, including COPD.</p>	F 757			

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F 757	Continued From page 17 The quarterly MDS assessment, dated 3/21/18, documented Resident #15 was severely cognitively impaired with no signs or symptoms of depression and did not experience behaviors. May 2018 Physician Orders documented Resident #15 received: * 250 mg of Depakote (anticonvulsant) twice a day for aggressive behaviors, dated 4/18/17 * Ativan 0.5 mg at bedtime for anxiety, dated 6/9/17 * Lexapro (antidepressant) 10 mg daily for depression, dated 2/10/17. Resident #15's care plan, revised 10/26/17, documented Resident #15 had a history of anxiety and agitation and received two psychotropic medications. The care plan interventions instructed staff to document all behaviors. On 5/17/18 at 9:30 AM, the DNS was unable to provide a consent for Resident #15's use of Lexapro. The DNS stated Resident #15's record did not include documentation of the monitoring of resident specific behaviors related to the use of Depakote, Ativan, or Lexapro.	F 757			
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 761		6/30/18	

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F 761	<p>Continued From page 18</p> <p>§483.45(h) Storage of Drugs and Biologicals</p> <p>§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review, and staff interview, it was determined the facility failed to ensure expired medications were not available for administration to 3 of 17 residents (#9, #12, and #15) residing in the facility who received medications. This failed practice created the potential for residents to receive expired medications with decreased efficacy. Findings include:</p> <p>On 5/17/18 at 10:00 AM, an inspection of the facility medication cart was completed with LPN #1 present. The following was observed during the inspection:</p> <p>a. A Medication Administration Record included a physician's order, dated 1/17/17, which documented Resident #9 received Norco 5-325 mg (hydrocodone/acetaminophen,) one tablet</p>	F 761	<p>F761 SS= D 483.45(g)(h)(1)(2) LABEL/STORE DRUGS & BIOLOGICALS</p> <p>What corrective actions will be accomplished for those residents found to be affected by the deficient practice. As noted on the 2567, the facility removed all expired meds from the medication cart during survey.</p> <p>How will you identify other resident(s) having the potential to be affected and what corrective action(s) will be taken. All residents receiving meds from the pharmacy could be affected. The medication cart was checked and all expired medications removed.</p> <p>What measures will be put in place to</p>		

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F 761	<p>Continued From page 19</p> <p>every 6 hours as needed for pain. The prescription label on the medication package documented the medication was delivered on 1/17/17 and was to be discarded after 1/17/18. The back of the medication package documented the expiration date as 10/2020.</p> <p>b. A Medication Administration Record included a physician's order, dated 12/23/16, which documented Resident #12 received Norco 5-325 mg (hydrocodone/acetaminophen,) one tablet every 6 hours as needed for pain. The prescription label on the medication package documented the medication was delivered on 11/2/16 and to discard it after 5/25/17. The back of the medication package documented the expiration date as 4/2019.</p> <p>c. A Medication Administration Record included a physician's order, dated 1/8/18, which documented Resident #15 received Lorazepam 0.5 mg at bedtime for agitation. The prescription label on the medication package documented the medication was delivered on 4/15/18 and to discard it after 5/14/18. The back of the medication package documented the expiration date as 3/2019.</p> <p>LPN #1 could not explain the reason for the different expiration dates for the medications. The DON placed a phone call to the pharmacy for clarification at that time. The DNS stated the pharmacy recently realized that this was confusing and have now started placing one expiration date on medication packages. The DNS and LPN #1 removed the medications for disposal.</p>	F 761	<p>ensure that the deficient practice does not recur.</p> <p>The DON has arranged with the Pharmacist to go through the facility med cart each month and make sure that there are not expired meds present. The nursing staff will also check expiration and duplicate dates on medications, when completing the monthly med changeover. Expired medications will be properly disposed and any medication cards found to have 2 expiration dates will be returned to the pharmacy for re-packaging. If meds are found to be mislabeled, the DON will contact pharmacy staff and troubleshoot these issues monthly until resolved.</p> <p>The DON had created a med cart tracking form to use and audit medications when filling the medication cart each month; checking for expired medications was added to this tracking form and discussed with the nursing staff at the 5/23/18 staff meeting. Pharmacist will use this in his monthly reviews. The DON will also re-review the plan of correction and procedures for checking medications for expirations with all nursing staff at the upcoming 6/27/18 staff meeting for compliance and questions.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur.</p> <p>The DON created a pharmacy tracking form for the Pharmacist to review when checking the medication cart each month and then return it to the DON, beginning</p>		

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F 761	Continued From page 20	F 761			
F 880 SS=D	<p>Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)</p> <p>§483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.</p> <p>§483.80(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:</p> <p>§483.80(a)(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;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p>	F 880	6/4/18. The DON will keep this audit form monthly hereafter and all discrepancies will be reported to the Pharmacy Review Committee and Pharmacy Consultant.	6/4/18	

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F 880	<p>Continued From page 21</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: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (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> <p>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(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, staff and student nurse interview, and policy review, it was determined</p>	F 880	F880 SS= D 483.80(a)(1)(2)(4)(e)(f) INFECTION PREVENTION & CONTROL		

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F 880	<p>Continued From page 22</p> <p>the facility failed to ensure infection control measures were consistently implemented when staff failed to utilize a barrier for a multi-resident use glucometer in resident rooms and on a medication cart. This was true for 1 of 2 sample residents observed during blood glucose monitoring (Resident #8.) This failure created the potential for the spread of infection among residents. Findings include:</p> <p>On 5/16/18 at 11:15 AM, Nursing Student #1 (NS #1) under the supervision of LPN #1, was observed as she prepared to assess Resident #8's blood glucose (BG). In the resident's room, NS #1 placed a glucometer(a medical device for determining glucose levels in the blood) used for multiple residents onto the resident's nightstand. NS #1 did not use a barrier under the glucometer when it was placed on the resident's nightstand. Upon completion of the BG assessment, NS #1 picked up the glucometer, returned to the medication cart, placed the used glucometer on top of the medication cart without a barrier, removed her gloves, sanitized her hands, applied new gloves, cleaned the glucometer with a disinfecting wipe, and placed the clean glucometer in the same spot on top of the medication cart where it had been before it was cleaned. NS #1 picked up the glucometer and went to assess another resident's blood glucose level.</p> <p>The facility's policy and procedure, dated 5/22/17, documented staff were to clean and disinfect the glucometer after each use, per manufacturer's guidelines. The procedure did not include documentation for ensuring the glucometer was placed on clean surfaces or</p>	F 880	<p>What corrective actions will be accomplished for those residents found to be affected by the deficient practice. A staff testing reminder sheet was placed in Resident #8 room and on the medication cart on 6/1/18 with tips for glucometer testing use, including the use of a barrier and infection control.</p> <p>How will you identify other resident(s) having the potential to be affected and what corrective action(s) will be taken. All residents using glucometer testing have the potential to be affected. A staff testing reminder sheet was placed in all resident rooms that have glucometer testing instructions and infection control reminders for use.</p> <p>What measures will be put in place to ensure that the deficient practice does not recur. Infection control and barrier use reminders during glucometer testing was discussed at the staff meeting held on 5/23/18. The facility policy on Glucose Point of Care Testing was updated to include instructions for using a barrier or clean surface to place the glucometer during use. This policy was updated 6/4/18 and copies given to all licensed staff completing glucometer testing.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur. An RN or the Infection Control Officer will</p>		

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F 880	Continued From page 23 using a barrier in resident care areas. On 5/16/18 at 11:30 AM, NS #1 and LPN #1 stated the use of a barrier would be a good idea.	F 880	perform a visual check of a random licensed staff member completing glucometer testing to check for compliance with all proper infection control precautions. This audit will begin 6/4/18 and will be done weekly for four weeks, then annually thereafter with licensed staff annual competency assessments. Audit findings and discrepancies will be corrected and reported to the DON and Infection Control Committee for further education and training needs.	6/30/18	
F 883 SS=F	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and	F 883			

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F 883	<p>Continued From page 24</p> <p>(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.</p> <p>§483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-</p> <p>(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;</p> <p>(iii) The resident or the resident's representative has the opportunity to refuse immunization; and</p> <p>(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:</p> <p>(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and</p> <p>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interview, policy review, and record review, it was determined the facility failed to develop and implement policies and processes to minimize the risk of residents acquiring, transmitting, or experiencing complications from pneumococcal pneumonia. This was true for 5 of</p>	F 883	<p>F883 SS= F 483.80(d)(1)(2) INFLUENZA & PNEUMOCOCCAL IMMUNIZATIONS</p> <p>What corrective actions will be accomplished for those residents found to</p>		

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F 883	<p>Continued From page 25</p> <p>5 sample residents (#2, #5, #6, #9, and #12) reviewed for pneumococcal vaccination, and had the potential to impact the other 12 residents residing in the facility. Specifically,</p> <p>a) The facility failed to ensure residents who were offered the pneumococcal vaccine received information and education consistent with current CDC recommendations for pneumococcal immunization.</p> <p>b) The facility's pneumococcal immunization process and pneumococcal immunization consent form did not reflect current CDC recommendations.</p> <p>c) The facility did not implement an immunization program to ensure residents' pneumococcal vaccine status were being tracked with receiving or declining the pneumococcal vaccines PCV13 the first year, followed by the PPSV23 one year later.</p> <p>Findings include:</p> <p>The Centers for Disease Control and Prevention (CDC) website, updated 11/22/16, documented recommendations for pneumococcal vaccination (PCV13 or Prevnar13®, and PPSV23 or Pneumovax23®) for all adults 65 years or older:</p> <p>* "Adults 65 years or older who have not previously received PCV13, should receive a dose of PCV13 first, followed 1 year later by a dose of PPSV23."</p> <p>*If the patient already received one or more doses of PPSV23, the dose of PCV13 should be</p>	F 883	<p>be affected by the deficient practice. Current CDC vaccine education forms were printed for PPSV23 and PCV13 and will be given to all family, POA or residents receiving or refusing the vaccines to review and initial. The forms will be placed with the vaccine consent forms in the resident chart. The physician vaccine standing order form was also updated for physician, resident or family/POA to sign for vaccine receipt, declination; the updated CDC timing algorithm for adults is now included for reference with the facility immunization tracking schedule.</p> <p>1. Resident #2 consent form and vaccine education form for PCV13 was given to POA to review and has been signed. The physician has signed the pneumococcal standing order and is scheduled to receive the vaccine. Resident #2 vaccine form from 9/5/16 was also edited by DON to reflect that the vaccine given at that time was PPSV23, which was the only one we carried. The DON will edit the MDS to reflect that the resident was not current on the pneumococcal vaccine series.</p> <p>2. Resident #5 had PPSV23 upon admission 2/14/18. The DON added Resident #5 on the facility immunization tracking form and will offer the second vaccine to the resident at the one-year mark of 2/14/19. The DON and staff will also discuss the importance of the vaccine series compliance with the family and resident at upcoming IDT meetings to encourage getting the vaccine when due.</p>		

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F 883	<p>Continued From page 26 given at least 1 year after they received the most recent dose of PPSV23."</p> <p>The facility's policy and procedure "Influenza/Pneumonia Vaccinations", dated 3/31/18, documented, "Pneumonia recipients will receive the Prevnar13-13 and then in one year the Pneumococcal-23. If a recipient is over age 65 years and has received both pneumococcal vaccines, then they will be considered vaccinated for life and will not need to receive either vaccine.</p> <p>The facility's policy "Pneumococcal Vaccine", dated 3/31/18, documented, "All residents over 65, that have not received the pneumococcal vaccine, will be offered the pneumonia series unless contraindicated....If a resident qualifies for the pneumococcal vaccine, then a staff member will give the resident or representative information on the benefits and risks of the pneumococcal vaccine prior to making a decision to be given the immunization. This will be documented in the medical record. The resident or representative will sign a consent form in the affirmative or negative for the vaccine. Consent will be placed in the medical record. Staff will give the appropriate pneumococcal vaccine if indicated and desired and then schedule a time for the rest of the series, if indicated."</p> <p>The facility's Pneumococcal Immunization Consent form, documented, "Algorithm for immunizing persons age 65 years and older...Algorithm for immunizing persons 64 years and younger." The facility staff was to document in a check box as follows: 1. "Pneumococcal vaccine NOT given. 2. Previously immunized for pneumococcal</p>	F 883	<p>The DON notified the POA of the declination and it was reviewed and signed by the POA. The DON will update the MDS to state that resident was not current on this vaccine. The DON also clarified on previous vaccine form that the vaccine given was PPSV23, according to Lot # information.</p> <p>3. Resident #6 family was contacted 6/1/18 to come sign the vaccine consent and education forms and the PCV13 vaccine will be given after that time. The DON was also able to find more past medical information about receiving the PPSV23 vaccine and this was noted in the chart and on the vaccine consent form. The DON will edit the MDS to reflect that the resident was not current on the pneumococcal vaccine series.</p> <p>4. Resident #9 had a historical notation of receiving the PPSV23 vaccine on 11/20/11, but no documentation to confirm. Since historical data is conflicting, we will be starting the series over with PCV13. The family was contacted 6/1/18 for vaccine consent and education review signatures to start the series. The DON will edit the MDS to reflect that the resident was not current on the pneumococcal vaccine series.</p> <p>5. Resident #12 now has an updated, signed vaccine consent and education form for PCV13. The DON updated the past record to indicate the previous vaccine given was the PPSV23. The DON will edit the MDS to reflect that the resident was not current on the pneumococcal vaccine series.</p>		

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F 883	<p>Continued From page 27</p> <p>pneumonia.</p> <p>3. Patient declined."</p> <p>The facility's consent form did not provide information for the PCV13 and PPSV23.</p> <p>1. Resident #2 was admitted to the facility on 10/1/17 with multiple diagnoses, including A-Fib (Atrial Fibrillation) and diabetes.</p> <p>Resident #2's quarterly MDS assessment, dated 4/28/18, documented Resident #2 was "up to date" with the Pneumococcal Vaccination.</p> <p>On 5/17/18 at 10:30 AM, the DNS provided Resident #2's Pneumococcal Vaccine Consent Form, dated 9/5/16, documented Resident #2 received the pneumococcal vaccine on 9/5/16. The consent did not document if the vaccine was the PCV13 vaccine, the PPSV23 vaccine, or tracking documentation of when Resident #2 was to receive the next vaccine.</p> <p>2. Resident #5 was admitted to the facility on 2/14/18 with multiple diagnoses, including anemia and a stroke.</p> <p>The quarterly MDS assessment, dated 4/12/18, documented Resident #5 was "up to date" with the Pneumococcal Vaccination.</p> <p>On 5/17/18 at 10:35 AM, the DNS provided Resident #5's Pneumococcal Vaccine Consent Form, dated 2/15/18, documented Resident #5 received the pneumococcal vaccine on 2/15/18. The consent form did not document if the vaccine was the PCV13, the PPSV23 vaccine, or tracking documentation when Resident #5 was to receive</p>	F 883	<p>How will you identify other resident(s) having the potential to be affected and what corrective action(s) will be taken. All residents that reside in our facility have potential to be affected by the associated complications of pneumonia. The DON has reviewed all resident charts. All residents received an initial pneumonia vaccine and 11 residents have been scheduled to receive updated pneumonia shots, per CDC recommendations. The updated vaccine information, consents, and information will be reviewed with the resident/family for approval and administered by 6/30/18.</p> <p>What measures will be put in place to ensure that the deficient practice does not recur.</p> <p>The DON updated the facility Pneumonia-Influenza vaccination policy to better match the CDC guidelines for administration of the vaccines. The DON has updated the pneumonia vaccine consent form and added the CDC recommended timing algorithm for adults to reference for the pneumonia vaccine administration schedule. The DON will also be signing up with the CDC website to receive future vaccine update notices via email to stay current on recommendations.</p> <p>An updated copy of the CDC vaccine education forms will be included with the consent form to educate residents and families about the risks and benefits, prior to administering the vaccines. Copies will</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135066	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/17/2018
NAME OF PROVIDER OR SUPPLIER POWER COUNTY NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 510 ROOSEVELT STREET (83211-1362) AMERICAN FALLS, ID 83211		
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F 883	<p>Continued From page 28 the next vaccine.</p> <p>3. Resident #6 was admitted to the facility on 4/13/18 with multiple diagnoses, including pulmonary embolism.</p> <p>Resident #6's admission MDS assessment, dated 4/26/18, was left blank for the Pneumococcal Vaccination.</p> <p>On 5/17/18 at 10:40 AM, the DNS was unable to provide the Pneumococcal Vaccine Consent Form for Resident #6. The DNS stated Resident #6 was not provided the consent on admission.</p> <p>4. Resident #9 was admitted to the facility on 11/11/13 with multiple diagnoses, including diabetes.</p> <p>The annual MDS assessment, dated 2/12/18, documented Resident #9 was "up to date" with the Pneumococcal Vaccination.</p> <p>On 5/17/18 at 10:45 AM, the DNS was unable to provide documentation Resident #9 received the pneumococcal vaccine and which type of vaccine, the PCV13, the PPSV23, or tracking documentation when Resident #9 was to receive the next vaccine.</p> <p>5. Resident #12 was admitted to the facility on 7/5/16 with multiple diagnoses, including hemiplegia.</p> <p>The quarterly MDS assessment, dated 4/21/18, documented Resident #12 was "up to date" with the Pneumococcal Vaccination.</p>	F 883	<p>be initialed by the resident or family and retained by the facility and given to the resident and/or family as well.</p> <p>The DON has worked with our Infection Control Officer to update the resident immunization program and created a tracking form for resident pneumonia and influenza vaccinations and their due dates along with the CDC timing algorithm for adults. The vaccine due dates were also added to the resident tracker and recaps of the MAR as a reminder, which are reviewed monthly at the Pharmacy Review Committee.</p> <p>The DON and Infection Control Officer will also re-review the facility policy and CDC guidelines on the pneumonia and influenza vaccines for residents with all nursing staff at the upcoming 6/27/18 staff meeting for compliance with vaccine orders, consents, education, and timing.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur.</p> <p>The DON will utilize the new immunization tracking form for auditing all resident vaccinations and their due dates. This audit will begin 6/4/18 and will be done monthly hereafter to continue tracking for all current and new resident vaccinations. Audit findings and discrepancies will be reported to the Infection Control Officer for further training needs and to the resident physician for vaccination concerns.</p>		

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

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F 883	<p>Continued From page 29</p> <p>On 5/17/18 at 10:50 AM, the DNS provided Resident #12's Pneumococcal Vaccine Consent Form, dated 7/5/16, documented Resident #12 "had Pneumovax in 2014". The consent form did not document if the vaccine was the PCV13 vaccine, the PPSV23, or tracking documentation of when Resident #12 was to receive the next vaccine.</p> <p>On 5/17/18 at 11:00 AM, the DNS was unaware of the most current CDC recommendations for the Pneumococcal Vaccination PCV13 and PPSV23, which included tracking all the resident's receiving the pneumococcal vaccination PCV13 dose first, followed by the PPSV23 one year later.</p> <p>These failed practices represented a systemic failure which increased residents' risk for contracting pneumonia with its associated complications of infection of the blood and covering of the brain and spinal cord which could cause death or brain damage.</p>	F 883			