



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  
FAX: (208) 364-1888  
E-mail: [fsb@dhw.idaho.gov](mailto:fsb@dhw.idaho.gov)

October 22, 2018

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

Provider #: 135064

Dear Ms. Sorensen:

On **September 28, 2018**, a survey was conducted at Countryside Care & Rehabilitation by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be an isolated deficiency that constitutes actual harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567 listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3.) **Please provide ONLY ONE completion date for each federal and state tag (if applicable) in column (X5) Completion Date** to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.

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 **November 1, 2018**. Failure

to submit an acceptable PoC by **November 1, 2018**, may result in the imposition of civil monetary penalties by **November 24, 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; 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*.

This agency is required to notify CMS Region X of the results of this survey. We are recommending that CMS impose the following remedy(ies):

- **Civil Monetary Penalty**
- **Denial of payment for new admissions effective December 28, 2018**

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **March 28, 2019**, 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**

Bonnie Sorensen, Administrator  
October 22, 2018  
Page 3 of 3

**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 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. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

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

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

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

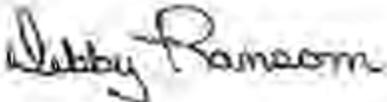
- BFS Letters (06/30/11)

[2001-10 Long Term Care Informal Dispute Resolution Process](#)

[2001-10 IDR Request Form](#)

This request must be received by **November 1, 2018**. If your request for informal dispute resolution is received after **November 1, 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: 01/11/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135064</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/28/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COUNTRYSIDE CARE &amp; REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1224 EIGHTH STREET RUPERT, ID 83350</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS  The following deficiencies were cited during the federal recertification survey conducted September 24, 2018 to September 28, 2018.  The surveyors conducting the survey were:  Teresa Kobza, RDN, LD, Team Coordinator Wendi Gonzales, RN  Abbreviations:  C&S = Culture and Sensitivity CDM = Certified Dietary Manager cm = centimeter CNA = Certified Nursing Assistant DNR = Do Not Resuscitate DON = Director of Nursing GDR = Gradual Dose Reduction LPN = Licensed Practical Nurse LSW = Licensed Social Worker MAR = Medication Administration Record MDS = Minimum Data Set mg = Milligram MRR = Medication Regimen Review RN = Registered Nurse POST = Physician Orders for Scope of Treatment PRN or prn = As Needed TAR = Treatment Administration Record UA = Urinalysis UTI = Urinary Tract Infection	F 000			
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2)  §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including:	F 604		10/31/18	

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

TITLE

(X6) DATE

Electronically Signed

10/31/2018

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135064</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/28/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COUNTRYSIDE CARE &amp; REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1224 EIGHTH STREET RUPERT, ID 83350</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 604	<p>Continued From page 1</p> <p>§483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2).</p> <p>§483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.</p> <p>§483.12(a) The facility must-</p> <p>§483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility failed to ensure residents were free from physical restraints, including bed and chair alarms, unless needed to treat the resident's medical symptoms. This was true for 1 of 1 resident (Resident #83) who was reviewed for restraints. This deficient practice created the potential for harm to residents, including decreased activities of daily living, increased risk for falls, fear movement</p>	F 604	<p>1. Resident #83 will be assessed by the DON or her designee to verify the need and safety risks associated with the use of bed and chair alarms. The physician and the resident's spouse will be notified promptly upon the completion of the assessment and orders for the alarms will be requested. The resident's care plan will be updated to reflect these corrections. Less restrictive interventions</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135064</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/28/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COUNTRYSIDE CARE &amp; REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1224 EIGHTH STREET RUPERT, ID 83350</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 604	<p>Continued From page 2</p> <p>may set off an alarm, and diminished sense of dignity. Findings include:</p> <p>Resident #83 was admitted to the facility on 9/6/18, with diagnoses which included left hip fracture.</p> <p>Resident #83's Admission Nursing Assessment, dated 9/6/18, documented he required the assistance of 2 people for ambulation and utilized a front wheeled walker.</p> <p>Resident #83's care plan area addressing poor safety awareness, dated 9/13/18, documented he had bed and chair alarms in place for fall prevention.</p> <p>On 9/24/18 at 12:14 PM, Resident #83 was observed in the dining room with a chair alarm on the back of his wheelchair. Resident #83 was observed with the chair alarm in place on 9/25/18 at 12:01, on 9/26/18 at 8:28 AM, and on 9/27/18 at 4:53 PM.</p> <p>On 9/27/18 at 5:05 PM, Resident #83 was observed in his recliner chair in his room, Resident #83 attempted to stand, and the alarm sounded multiple times.</p> <p>Resident #83's clinical record did not include assessments of the medical need for the bed and chair alarms, orders for the alarms, less restrictive interventions that failed or consents for the alarms.</p> <p>On 9/27/18 at 6:55 PM, the DON stated the facility did not know they had to assess bed and chair alarms as possible restraints. The DON</p>	F 604	<p>that have failed have been noted on the alarm consent form.</p> <p>2. The facility has determined that all residents have the potential to be affected.</p> <p>All residents with alarms will be assessed for need and safety risks.</p> <p>3. An in-service education program will be conducted by the DON and the Administrator with all direct care staff addressing circumstances that require the use of bed and or chair alarms and the hazards associated with their use. A policy will be made, an assessment and consent form will be created and to address alarms.</p> <p>4. The DON, or Designee, will conduct a random audit of five (5) residents weekly for four (4) consecutive weeks. These residents will be assessed and interviewed/observed to ensure that the reasons for the use of the bed/chair alarms are properly identified, evaluated, documented and care planned.</p> <p>This plan of correction will be monitored at the monthly Quality Assurance meeting until such time consistent substantial compliance has been met.</p>		

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

PRINTED: 01/11/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135064</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/28/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COUNTRYSIDE CARE &amp; REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1224 EIGHTH STREET RUPERT, ID 83350</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 604	Continued From page 3 stated they had not completed assessments for Resident #83's bed and chair alarms.	F 604			
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 recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the	F 656		11/16/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135064</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/28/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COUNTRYSIDE CARE &amp; REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1224 EIGHTH STREET RUPERT, ID 83350</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 656	<p>Continued From page 4</p> <p>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 policy review, record review, and staff interview, it was determined the facility failed to develop and implement comprehensive resident-centered care plans. This was true for 4 of 14 residents (#1, #5, #6, and #11) whose care plans were reviewed. Resident #1's care plan did not address all pertinent behaviors and interventions to address the behaviors. Resident #1's, Resident #5's, Resident #6's, and Resident #11's care plans did not address their resuscitation code status and wishes identified in their living wills/advance directives. These failures created the potential for a decline in their health and the potential for harm due to inappropriate care. Findings include:</p> <p>1. The facility's psychoactive medications policy and procedures, undated, documented the resident's care plan would be revised to describe the signs and symptoms of the behavior, to provide instruction to monitor for signs and symptoms, instruction on how to manage the behaviors should they occur, and to provide non-pharmacological interventions to use prior to the administration of PRN medications.</p> <p>Resident #1 was admitted to the facility on 4/21/17, with multiple diagnoses including dementia and Alzheimer's disease.</p>	F 656	<p>1. Resident <input type="checkbox"/>s #1, #5, #6, and #11 <input type="checkbox"/>s care plans will be reviewed and updated by the DON or her designee to reflect the following changes. Resident #1 <input type="checkbox"/>s care plan will address all pertinent behaviors as well as advance directive and code status. Resident #5, #6 and #11 <input type="checkbox"/>s care plans will address their resuscitation code status and wishes identified in their living wills/advanced directives.</p> <p>2. The facility has determined that all residents have the potential to be affected.</p> <p>A record review of all residents care plans will be done to address pertinent behaviors and their resuscitation code status and wishes identified in their living wills/advanced directives.</p> <p>3. All interdisciplinary care plan team members responsible for writing care plans will be re-educated on the facility <input type="checkbox"/>s policy and procedure for developing comprehensive care plans.</p> <p>4. Care Plans will be reviewed weekly in accordance with the care plan review</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135064</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/28/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COUNTRYSIDE CARE &amp; REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1224 EIGHTH STREET RUPERT, ID 83350</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 656	<p>Continued From page 5</p> <p>Resident #1's physician orders, dated 2/7/18 and 7/13/18, documented Cymbalta (an antidepressant) 30 mg by mouth daily for depression and pain, and Xanax (an anti-anxiety medication) 0.25 mg by mouth two times a day for anxiety.</p> <p>Resident #1's psychoactive medication consent, dated 2/9/18 and 7/13/18, documented specific target behaviors of her anxiety. The behaviors for the use of Xanax included calling out, restlessness, repetitive verbalizations, crying out, and insomnia. The indications for use of Cymbalta included verbalizations concerning a fear of dying, being abandoned, pain, and sad mood.</p> <p>Resident #1's psychotropic drug committee update, dated 7/27/18, documented Resident #1 continued on Cymbalta 30 mg every day for depression and pain, and she was started on Xanax 0.25 mg two times a day. The update documented Resident #1 continued to call out repeatedly and refused to take medications.</p> <p>Resident #1's behavior monitoring log, dated 9/1/18 through 9/27/18, documented Resident #1 exhibited the following behaviors:</p> <ul style="list-style-type: none"> <li>* cursing at others - 20 times</li> <li>* screaming at others - 29 times</li> <li>* hitting others - 11 times</li> <li>* pushing others - 7 times</li> <li>* throwing/smearing food or bodily waste - 3 times</li> <li>* threatening others - 4 times</li> <li>* disrobing in public - 1 time</li> </ul>	F 656	<p>schedule by the MDS Coordinator. All care plans will be updated as indicated.</p> <p>The DON, or designee, will conduct a random weekly audit of four (4) care plans for six (6) consecutive weeks. Random audits will be completed to ensure that comprehensive care plans are developed for residents.</p> <p>Findings of this audit will be monitored at the monthly Quality Assurance meeting until such time consistent substantial compliance has been met.</p>		

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

PRINTED: 01/11/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135064</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/28/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COUNTRYSIDE CARE &amp; REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1224 EIGHTH STREET RUPERT, ID 83350</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 656	<p>Continued From page 6</p> <p>* grabbing others - 10 times</p> <p>One or more of the above behaviors were documented on 19 days of the 27 day period.</p> <p>Resident #1's care plan identified her risk for alteration in her cognition related to environment changes, changes in medication, and her history of insomnia and anxiety. The care plan also identified Resident #1 had repetitive verbalizations related to her dementia and anxiety. Resident #1's care plan did not identify and include interventions related to her behaviors of cursing at others, screaming at others, hitting others, pushing others, throwing/smearing food or bodily waste, threatening others, disrobing in public, and grabbing others.</p> <p>On 9/27/18 at 3:40 PM, LPN #1 stated behaviors were documented in notebooks at the nurses' station which enabled CNAs to document specific and detailed narratives related to behaviors from the use of psychotropic medications. CNAs reported to the nurse and then the nurse documented with summarized nurses' notes. LPN #1 stated behaviors were monitored and documented in the facility's behavior monitoring chart. LPN #1 stated the behaviors documented were from a list of general behaviors that were not necessarily unique to the resident.</p> <p>On 9/27/18 at 9:10 AM, the LSW stated behaviors of the resident taking psychotropic medications were resident-focused and were to be part of the care plan. The LSW provided example documentation of care plans that did not address related behaviors specific to the resident.</p>	F 656			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135064</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/28/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COUNTRYSIDE CARE &amp; REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1224 EIGHTH STREET RUPERT, ID 83350</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 656	Continued From page 7  2. Care plans did not include advance directive or code status information. Examples include:  a. Resident #1 was admitted to the facility on 4/21/17, with multiple diagnoses including dementia and Alzheimer's disease.  Resident #1's POST, dated 2/28/14, documented a DNR code status and the presence of a living will include a status of DNR.  Resident #1's care plan did not include documentation of her DNR status and her wishes identified in her living will.  b. Resident #5 was admitted to the facility on 10/15/15, with multiple diagnoses including dementia and depression.  Resident #5's POST, dated 10/15/15, documented a DNR code status and the presence of a living will which included a status of DNR.  Resident #5's physician orders, dated 12/30/15, documented a DNR code status.  Resident #5's care plan did not include documentation of her code status or wishes identified in her living will.  c. Resident #6 was readmitted to the facility on 12/5/17 with diagnoses which included Parkinson, benign prostatic hyperplasia (enlarged prostate glade), UTI, and chronic kidney disease.	F 656			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135064</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/28/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COUNTRYSIDE CARE &amp; REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1224 EIGHTH STREET RUPERT, ID 83350</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 656	Continued From page 8 A quarterly MDS assessment, dated 7/3/18, documented Resident #6 was cognitively intact.  Resident #6's September 2018 Physician Orders included an order for Full Code.  Resident #6's POST, dated 2/14/13, documented his code status was Full Code.  Resident #6 did not have a care plan area addressing his code status.  d. Resident #11 was readmitted to the facility on 12/20/17 with diagnoses which included pain in the right and left knee and muscle weakness.  A quarterly MDS assessment, dated 8/21/18, documented Resident #11 was cognitively intact and required extensive assistance of 2 staff members for all care except eating.  Resident #11's September 2018 Physician Orders included an order for DNR.  Resident #11's POST, dated 7/6/13, and Living Will, dated 2/27/91, documented she wished her code status to be DNR.  Resident #11 did not have a care plan area addressing her living will and code status.  On 9/27/18 at 4:16 PM, The LSW and RN #1 stated the care plan did not have a section currently regarding residents' code status. The LSW the care plans used to include code status, prior to the implementation of the new computer system.	F 656			
F 684	Quality of Care	F 684		11/16/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135064</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/28/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COUNTRYSIDE CARE &amp; REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1224 EIGHTH STREET RUPERT, ID 83350</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 684 SS=D	<p>Continued From page 9 CFR(s): 483.25</p> <p>§ 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 observation, record review, and staff interviews, it was determined the facility failed to ensure appropriate interventions were consistently implemented and include accurate documentation in the record related to non-pressure related skin management. This was true for 1 of 4 residents (Resident #4) whose records were reviewed for skin integrity management. This failed practice created the potential for harm when skin impairments were not treated effectively, and a resident was not provided education to prevent further skin breakdown. Findings include:</p> <p>Resident #4 was readmitted to the facility on 12/5/17, with diagnoses which included dementia.</p> <p>A quarterly MDS assessment, dated 8/28/18, documented Resident #4 had moderate cognitive impairment and required extensive assistance of 1 staff member with cares. The MDS documented he had no current skin impairments.</p> <p>a. Resident #4 developed a venous stasis ulcer</p>	F 684	<p>1. Resident #4's skin will be assessed by the DON or her designee, for loss of skin integrity; interventions for any areas will be identified and recorded into the resident's medical record. Interventions will be included in the resident's comprehensive care plan. The resident's record will be reviewed for conflicting wound assessment data and consistent wound treatment. The resident will be notified of risks and benefits of compliance with interventions.</p> <p>2. The facility has determined that all residents have the potential to be affected.</p> <p>All residents will have their skin assessed by a LN, any areas will be documented and interventions will be included in the comprehensive care plan. Residents will be notified of any risks and benefits of compliance to interventions.</p> <p>3. An in-service education program will be</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135064</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/28/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COUNTRYSIDE CARE &amp; REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1224 EIGHTH STREET RUPERT, ID 83350</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 684	<p>Continued From page 10</p> <p>on his right ankle and the facility failed to identify and implement interventions timely.</p> <p>Resident #4's Skin Inspection Report, dated 9/7/18, documented Resident #4's skin was "not intact" with an existing injury. Two Nurse's Progress Notes date 9/7/18 did not include documentation related to Resident #4's skin injury.</p> <p>A fax to the physician, dated 9/10/18, documented Resident #4 was complaining of pain to his right outer ankle and had a 1 cm by 1 cm reddened area. The physician responded to the fax with a response of "saw in office - looks like venous stasis (related to weak blood flow)."</p> <p>A Nurse's Progress Note, dated 9/10/18, documented Resident #4 complained of right outer ankle pain and a 1 cm by 1 cm reddened area was found on his right ankle. The note documented the area was blanchable (loses all redness when pressed).</p> <p>b. Resident #4's Wound Assessment Reports documented a "right lateral malleolus (ankle bone), redness and dark purple discoloration" and an unstageable deep tissue injury to his "right heel; deep tissue injury to right ankle bone." The documentation included conflicting data when it described 2 areas, rather than the 1 to his right ankle.</p> <p>A Wound Assessment Report, dated 9/10/18, documented Resident #4 had a "new wound" on his right lateral malleolus with redness and dark purple discoloration, measuring 1 cm by 1 cm. The Wound Assessment Reports, dated 9/10/18</p>	F 684	<p>conducted on November 6 and 8, 2018 by the DON and the Administrator with all direct staff addressing the importance of timely identification and implementation of interventions for loss of skin integrity, The education will also include the importance of accurate documentation, consistent wound treatment and notifying the resident of risks and benefits of compliance with interventions.</p> <p>A Body Audit Communication Tool will be provided to staff as an avenue to report new skin issues to nursing, wound nurse and the IDT.</p> <p>4. The DON, or designee, will conduct a random audit of five (5) residents weekly for four (4) consecutive weeks. These residents will be assessed and a record review will be done for timely identification, documentation accuracy, treatment consistency, and Risks and Benefits.</p> <p>Findings of this audit will be monitored at the monthly Quality Assurance meeting until such time consistent substantial compliance has been met.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135064</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/28/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COUNTRYSIDE CARE &amp; REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1224 EIGHTH STREET RUPERT, ID 83350</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 684	<p>Continued From page 11 and 9/21/18, documented the wound measured 1 cm by 1 cm with redness and had a 0.5 cm purple area in the center. The Wound Assessment Report, dated 9/21/18, documented the nurse applied a corn pad to Resident #4's wound bed.</p> <p>A Wound Assessment Report, dated 9/11/18, documented Resident #4 had a wound identified on 9/10/18, and was located on his "right heel; deep tissue injury to right ankle bone," and measured 1 cm by 0.8 cm. The Wound Assessment Report documented the wound was an "unstageable pressure ulcer" due to suspected deep tissue injury. The Wound Assessment Report documented Resident #4's wound had split open and scabbed over.</p> <p>Resident #4's Wound Assessment Reports dated 9/11/18, 9/18/18, and 9/25/18, each referenced the wound as "right heel; deep tissue injury to right ankle bone," which measured 1 cm by 0.8 cm and was described as an unstageable pressure ulcer. On 9/25/18, the wound was documented as measuring 0.8 cm by 0.5 cm with a purplish brown scab in the wound bed.</p> <p>The same wound was documented as two separate injuries and were documented with different measurements. On 9/10/18 and 9/21/18 the wound measured as 1 cm by 1 cm and on 9/11/18 the wound was documented as 1 cm by 0.8 cm and continued to be documented as smaller. The documentation was unclear as to what size the wound was and where it was located.</p> <p>c. Resident #4's wound treatments were not</p>	F 684			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135064</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/28/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COUNTRYSIDE CARE &amp; REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1224 EIGHTH STREET RUPERT, ID 83350</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 684	<p>Continued From page 12 consistent as follows:</p> <p>Resident #4's Physician Orders included a corn pad to his right ankle every three days and PRN, ordered 9/14/18.</p> <p>Resident #4's 9/1/18 through 9/26/18 TAR documented the corn pad was applied on Resident #4's right ankle on 8/19/18. The corn pad was not applied on 9/14/18 and 9/17/18 as ordered.</p> <p>d. The facility did not review risk versus benefits with Resident #4 about laying in one position for extended periods of time or issues with not floating his heels and refusing to reposition himself.</p> <p>The care plan area addressing Resident #4's communication, undated, documented Resident #4 was Spanish speaking. The care plan documented staff were to utilize a "Spanish speaking staff when able."</p> <p>Resident #4's clinical record did not contain documentation the staff reviewed risk versus benefits with Resident #4 about his position while in bed or encouraged him to reposition.</p> <p>Resident #4's Turn and Reposition Roster, from 9/1/18 through 9/27/18, documented the following options, "Not applicable Independent or able to move self," "Declined to be turned," and "Yes was turned," once per shift. The facility had three shifts for staff to document the responses. The Roster for Resident #4 was documented as "Not Applicable or Independent" 46 out of 78 opportunities, "Declined" 13 out of 78</p>	F 684			

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

PRINTED: 01/11/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135064</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/28/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COUNTRYSIDE CARE &amp; REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1224 EIGHTH STREET RUPERT, ID 83350</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 684	<p>Continued From page 13 opportunities, and "Yes was turned" 19 out 78 opportunities.</p> <p>On 9/24/18 from 12:30 PM through 3:38 PM, Resident #4 was observed laying on his right side with one shoe on his right foot, and no shoe on his left foot. Resident #4's ankle was flat against the bed and not floated.</p> <p>On 9/27/18 at 10:50 AM through 11:40 AM, Resident #4 was observed lying in bed on his right side with shoes on both feet and his feet were not floated.</p> <p>On 9/27/18 11:48 AM the DON stated Resident #4 should have his ankle floated. The DON stated Resident #4 would reposition himself and remove a pillow if one was placed to float his heels. The DON stated Resident #4's care plan did not contain documentation about his refusals to reposition or removing a pillow. The DON stated the staff were not monitoring Resident #4 for refusals aside from what was documented on the repositioning schedule. The DON stated she could not locate documentation of risk verses benefits being discussed with Resident #4 regarding his positioning and refusals. The DON stated if a resident laid in one spot for extended periods of time a wound could worsen, and pressure could be suspected. The DON stated the physician had determined Resident #4's wound was a venous status ulcer. The DON stated the corn pad should have been changed per physician's orders.</p> <p>On 9/27/18 at 2:24 PM, the Wound RN stated she did not discuss risks verses benefits with Resident #4 regarding his positioning and floating</p>	F 684			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135064</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/28/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COUNTRYSIDE CARE &amp; REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1224 EIGHTH STREET RUPERT, ID 83350</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 684	Continued From page 14 of his heels. The Wound RN stated the staff did not document Resident #4's refusal to float his heels unless it was in the nurses' notes. The Wound RN stated the CNAs were to inform the nursing staff if residents were refusing things like floating heels, so the nurses would be able to assess the wound and notify the physician for further orders if needed. The Wound RN was not aware Resident #4's treatment was not consistently applied. The Wound RN said she thought Resident #4 was removing his dressing. The Wound RN could not find documentation of Resident #4 removing his dressing.	F 684			
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)  §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review, policy review, observation, and resident and staff interview, it was determined the facility failed to ensure residents did not develop avoidable pressure ulcers. This was true for 1 of 4 residents (Resident #23) reviewed for pressure ulcers.	F 686	1. Resident #23's skin will be assessed by the DON or her designee, for loss of skin integrity; interventions for any areas will be identified and recorded into the resident's medical record. Interventions will be included in the resident's	11/16/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135064</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/28/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COUNTRYSIDE CARE &amp; REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1224 EIGHTH STREET RUPERT, ID 83350</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 686	<p>Continued From page 15</p> <p>Resident #23 was harmed when she developed 2 unstageable pressure ulcers on her left foot. Findings include:</p> <p>The facility's undated Skin Assessment Policy and Procedure documented a licensed or registered nurse was to assess a resident's "full body" upon admission/readmission and weekly thereafter.</p> <p>The facility's undated Pressure Ulcer Policy and Procedure documented staff would screen for pressure ulcers during routine skin assessments. The policy documented if an area was discovered the nurse would implement interventions, notify the physician, family, and the wound nurse. The policy documented the wound would be measured and a description of the wound would be completed. The policy also documented the wound would be assessed and measured weekly and as needed.</p> <p>Resident #23 was readmitted to the facility on 5/11/18, with diagnoses which included multiple sclerosis.</p> <p>Resident #23's Braden Risk Assessment (a tool used to assess the risk for developing pressure ulcers), dated 3/26/18, documented no impairments and she was at mild risk for skin breakdown.</p> <p>A quarterly MDS assessment, dated 8/21/18, documented Resident #23 was cognitively intact and documented she required extensive assistance of one to two staff members with all cares except eating. The MDS documented Resident #23 had two unstageable pressure</p>	F 686	<p>comprehensive care plan. The resident's record will be reviewed for conflicting wound assessment data and consistent wound treatment.</p> <p>2. The facility has determined that all residents who are at risk for pressure ulcers have the potential to be affected. The DON or her designee will review all of the resident's Braden Scores for risk for pressure ulcers. Those who are at risk will have a skin assessment completed. Interventions for any areas will be identified and recorded into the resident's medical record. Interventions will be included in the resident's comprehensive care plan.</p> <p>3. An in-service education program will be conducted on November 6 and 8, 2018 by the DON and the Administrator with all direct staff addressing the importance of timely identification and implementation of interventions for loss of skin integrity, The education will also include the importance of accurate documentation and consistent wound treatment.</p> <p>A Body Audit Communication Tool will be provided to staff as an avenue to report new skin issues to nursing, wound nurse and the IDT.</p> <p>4. The DON, or designee, will conduct a random audit of five (5) residents weekly for four (4) consecutive weeks. These residents will be assessed and a record review will be done for timely</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135064</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/28/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COUNTRYSIDE CARE &amp; REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1224 EIGHTH STREET RUPERT, ID 83350</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 686	<p>Continued From page 16</p> <p>ulcers. A previous quarterly MDS assessment, dated 5/29/18, documented Resident #23 had one unstageable pressure ulcer, and a previous MDS assessment, dated 3/6/18, documented Resident #23's skin was intact, and she did not have a pressure ulcer.</p> <p>a. Resident #23 developed an unstageable pressure ulcer on the top of her left second toe and the facility failed to identify and implement interventions timely. Example includes:</p> <p>Resident #23's Skin Inspection Report, dated 3/30/18, documented Resident #23's skin was "not intact" with an existing injury. An assessment describing the injury was not completed on 3/30/18.</p> <p>A Nurse's Progress Note, dated 3/30/18, documented Resident #23's skin was intact with "no new skin issues noted." The Skin Inspection Report and the nursing progress note contained conflicting data.</p> <p>A Skin Inspection Report, dated 4/6/18, documented Resident #23's skin was "not intact" with an existing injury.</p> <p>A Wound Assessment Report, dated 4/6/18, documented Resident #23 had a "new wound" on the top of her left second toe. The assessment documented the wound was an unstageable pressure ulcer with 100% eschar (black dead skin) in the wound bed and measured 0.7 cm by 0.6 cm. The assessment documented Resident #23 "recently" received new shoes and the staff thought the pressure ulcer was from the toe rubbing inside the shoe.</p>	F 686	<p>identification, documentation accuracy and treatment consistency.</p> <p>Findings of this audit will be monitored at the monthly Quality Assurance meeting until such time consistent substantial compliance has been met.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135064</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/28/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COUNTRYSIDE CARE &amp; REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1224 EIGHTH STREET RUPERT, ID 83350</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 686	<p>Continued From page 17</p> <p>A Nurse's Progress Note, dated 4/6/18, documented Resident #23's skin was "warm and pink." The Skin Inspection Report and the nursing progress note contained conflicting data. The facility did not identify and document the presence of Resident #23's pressure ulcer on her second toe prior to it becoming unstageable.</p> <p>The care plan area addressing Resident #23's pressure ulcer, initiated 4/6/18, documented Resident #23's left foot, on the top of her second toe, had an unstageable pressure ulcer. The care plan documented staff would measure and assess her skin weekly and apply treatments as ordered.</p> <p>b. Resident #23's Weekly Skin Inspection Reports were not consistently completed. Examples include:</p> <p>Resident #23's Weekly Skin Inspection Reports were not completed between the dates of 4/28/18 and 6/15/18, 6/15/18 and 7/21/18, 7/21/18 and 8/24/18, and 8/24/18 and 9/07/18.</p> <p>Resident #23's Nurse's Progress Notes, dated 5/11/18, 5/18/18, 5/25/18, 6/1/18, 6/8/18, 6/22/18, 6/29/18, 7/6/18, 7/13/18, 7/20/18, 7/27/18, 8/3/18, 8/10/18, 8/17/18, 8/24/18, 9/7/18, and 9/14/18 documented she had not developed "new skin issues." Resident #23's Nurse's Progress Notes did not include consistent skin assessments and staff did not assess her skin between the dates of 4/27/18 and 5/11/18 (12 days), and 8/24/18 and 9/7/18 (14 days).</p> <p>c. Resident #23's Wound Assessment Reports</p>	F 686			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135064</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/28/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COUNTRYSIDE CARE &amp; REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1224 EIGHTH STREET RUPERT, ID 83350</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 686	<p>Continued From page 18</p> <p>documented unstageable pressure ulcers to the top of her left second toe; to the pad of the left foot, under the fifth digit (toe); the pad of the foot, under the fourth digit; and an unspecified area to the left pad of her foot. The documentation included conflicting data as to size, location, and the number of pressure ulcers Resident #23 developed. Examples include:</p> <p>Resident #23's Wound Assessment Reports for the top of her second toe were not consistently completed between the dates of 4/6/18 and when it resolved on 8/24/18, to 0 cm by 0 cm. Resident #23's toe wound worsened to 0.8 cm by 0.8 cm on 5/14/18 and remained that size until 8/10/18. Resident #23's wound was not assessed for 12 days between 6/8/18 and 6/20/18.</p> <p>A Nurse's Progress Note, dated 5/31/18, documented Resident #23 had "two dark black scabs" on the ball of her left foot. The progress note documented the first one was located under her 5th digit, measuring 2 cm by 1.7 cm and the second was located under her 4th digit, measuring 1.4 cm by 1 cm. The facility did not identify Resident #23's pressure ulcers on the ball of her foot prior to them becoming unstageable.</p> <p>A Wound Assessment Report, dated 5/31/18, documented Resident #23 had a "new wound" on the ball of her left foot, under the 4th digit, measuring 1.4 cm by 1 cm. The assessment documented the wound was an unstageable pressure ulcer with 100% eschar (dry, dark dead tissue) in the wound bed. The assessment documented Resident #23 had edema "but not to the bottom of her foot." Resident #23's Wound</p>	F 686			

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

PRINTED: 01/11/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135064</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/28/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COUNTRYSIDE CARE &amp; REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1224 EIGHTH STREET RUPERT, ID 83350</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 686	<p>Continued From page 19</p> <p>Assessment Reports were dated 5/31/18, 6/4/18, 6/8/18, 6/12/18 and 6/22/18. On 6/22/18 the wound was documented as measuring 1.3 cm by 1 cm with 100% eschar in the wound bed. The report documented Resident #23's "area remains stable with an intact superficial black scab." The 6/22/18 Wound Assessment Report documented the wound as resolved on that date, when the wound was still present. Resident #23's wound was not assessed for 10 days between 6/12/18 and 6/22/18.</p> <p>A Wound Assessment Report, dated 5/31/18, documented Resident #23 had a "new wound" on the ball of her left foot, under the 5th digit, measuring 2 cm by 1.7 cm. The assessment documented the wound was an unstageable pressure ulcer with 100% eschar in the wound bed. The assessment documented Resident #23 had edema "but not to the bottom of her foot." Resident #23's Wound Assessment Reports for this wound were dated 5/31/18, 6/4/18, 6/8/18, 6/12/18 and 6/20/18. On 6/20/18 the wound was documented as measuring 1.8 cm by 1.6 cm with 100% eschar in the wound bed. The report documented Resident #23's "area remains stable with an intact superficial black scab." The 6/20/18 Wound Assessment Report documented the wound as resolved on 6/22/18 which was contradictory to the assessment of the wound. Resident #23's wound was not assessed for 8 days between 6/12/18 and 6/20/18.</p> <p>A Wound Assessment Report, dated 6/22/18, documented Resident #23 had a "new wound" on the ball of her left foot, under the 5th digit, measuring 1 cm by 1 cm. The assessment documented the wound was an unstageable</p>	F 686			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135064</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/28/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COUNTRYSIDE CARE &amp; REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1224 EIGHTH STREET RUPERT, ID 83350</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 686	<p>Continued From page 20</p> <p>pressure ulcer with 100% eschar in the wound bed. The report documented Resident #23's wound started as a black "bruise in 5/31/18" and it turned into a black "scab." Resident #23's previous Wound Assessment Reports did not describe the wound as a bruise but as 100% eschar. Resident #23's Wound Assessment Reports related to this described wound were dated 6/22/18, 6/25/18, 6/29/18, 7/2/18, 7/6/18, 7/13/18, and 7/20/18. On 7/20/18 the wound was documented as measuring 0.3 cm by 0.3 cm with 25% eschar in the wound bed. The Wound Assessment Reports documented Resident #23's wound was healing, and scar tissue was forming. Resident #23's clinical record did not include follow up wound assessments to the ball of her left foot, under the 5th digit after 7/20/18.</p> <p>A Wound Assessment Report, dated 7/27/18, documented Resident #23 had a "wound" on her left pad of her foot, measuring 0.3 cm by 0.3 cm. The assessment documented the wound was an unstageable pressure ulcer with 100% epithelial tissue (a thin layer of skin) in the wound bed. The Wound Assessment Report documented Resident #23's "scab" had resolved and scar tissue remained. Resident #23's Wound Assessment Reports for this wound were dated 7/27/18, 8/1/18, 8/8/18, 8/10/18, 8/17/18, and 8/24/18. On 8/24/18 the wound was documented as measuring 0 cm by 0 cm and resolved.</p> <p>d. Resident #23's treatments were not consistent as follows:</p> <p>Resident #23's April 2018 TAR documented she was to have a corn pad administered on her second left toe as needed. The TAR did not</p>	F 686			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135064</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/28/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COUNTRYSIDE CARE &amp; REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1224 EIGHTH STREET RUPERT, ID 83350</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 686	<p>Continued From page 21 include documentation a corn pad was administered.</p> <p>Resident #23's May 2018 TAR did not document treatments or the use of a corn pad for her second left toe after if worsened on 5/14/18. The TAR documented Resident #23 was to wear sandals or socks to her left foot until healing was evident, ordered 4/23/18.</p> <p>Resident #23's June 2018 TAR documented staff was to monitor the ball of her "left foot with the skin checks" and were instructed to leave the foot brace off (undated). The June TAR did not document Resident #23's second left toe treatments or the corn pad. The TAR documented Resident #23 was to wear sandals or socks on her left foot until healing was evident, ordered 4/23/18.</p> <p>Resident #23's July 2018 TAR documented staff were to apply medi-honey (a wound gel) and optifoam (a type of wound dressing made of foam) to her left second toe wound every day and as needed, ordered 7/30/18. The TAR documented administration was completed on 7/30/18. The TAR did not document it was completed on 7/31/18. Resident #23's wounds to the bottom of her left foot were not documented on the July TAR.</p> <p>Resident #23's August 2018 TAR was requested on 9/27/18 and was not provided for review.</p> <p>On 9/24/18 at 3:53 PM, Resident #23 stated she had areas of skin breakdown on her legs, however they were healed. Resident #23 stated she could reposition her bottom in the chair when</p>	F 686			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135064</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/28/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COUNTRYSIDE CARE &amp; REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1224 EIGHTH STREET RUPERT, ID 83350</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 686	<p>Continued From page 22</p> <p>she needed to, to prevent skin breakdown. Resident #23 was observed in her motorized wheelchair. The left foot pedal was covered with sheep skin and a pad, and the right foot pedal was not covered.</p> <p>On 9/26/18 at 7:03 AM, Resident #23 was observed assisted out of bed by CNA #1 and CNA #2. CNA #2 was observed applying lotion to Resident #23's legs and feet. Resident #23's feet did not have areas of skin impairment. CNA #1 assisted Resident #23 with placing stockings on her legs and applied braces on her legs. Resident #23 was observed as she was assisted into her wheelchair. Resident #23's wheelchair was observed with the left foot pedal covered with sheep skin and a pad and the right foot pedal was not covered.</p> <p>On 9/26/18 at 9:35 AM, Resident #23 stated she thought the pressure ulcers developed from the leg braces or the foot pedals. Resident #23 stated the foam and sheep skin was not on her wheelchair before the two wounds developed on the bottom of her foot.</p> <p>On 9/27/18 at 2:41 PM, the Wound RN stated nurses should complete skin assessments weekly during a resident's shower. The Wound Nurse stated the skin assessments were mostly documented in the nurses' progress notes. The Wound RN stated there were two wounds, one on the bottom of Resident #23's foot and one on the top of her second left toe. The Wound RN stated the wound documentation was inconsistent. The Wound RN could not explain the contradictory or conflicting data. The Wound RN stated the wound areas were small and the</p>	F 686			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135064</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/28/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COUNTRYSIDE CARE &amp; REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1224 EIGHTH STREET RUPERT, ID 83350</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 686	Continued From page 23 risk vs. benefits about wearing her shoes, was discussed with Resident #23 when the first pressure ulcer was discovered. The Wound RN stated the nurses should follow the physician's orders for treatments.	F 686			
F 697 SS=D	Pain Management CFR(s): 483.25(k)  §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, policy review, resident and staff interview, and record review, it was determined the facility failed to ensure a method for evaluating the effectiveness of residents' pain management plans was in place for 2 of 3 residents (#11 and #21) reviewed for pain. This failure created the potential for harm if residents experienced ongoing severe pain or increased pain and the facility did not identify it. Findings include:  The facility's undated Pain Assessment and Management Policy and Procedure, documented the facility would manage residents' pain. The policy documented all pain medications would be administered per physician's orders and the staff would assess for effectiveness and or side effects. This policy was not followed.  1. Resident #11 was readmitted to the facility on 12/20/17, with diagnoses which included pain in	F 697	11/16/18		
			1. Resident's #11 and #21's pain will be assessed by the DON or her designee. A pain management log will be assigned where symptoms of pain and the effectiveness of interventions can be documented. A prn pain verification order request will be sent to the resident's physicians to provide guidance for the nurses of which pain medications should be given for each level of pain. This request will be directly tied to the standardized pain scale used in the facility.  2. The facility has determined that all residents who have pain have the potential to be affected. All residents who are on pain management will have a place in their permanent record where nursing staff can document symptoms of pain as well as the effectiveness of		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135064</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/28/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COUNTRYSIDE CARE &amp; REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1224 EIGHTH STREET RUPERT, ID 83350</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 697	<p>Continued From page 24</p> <p>the right and left knee and muscle weakness.</p> <p>A quarterly MDS assessment, dated 8/21/18, documented Resident #11 was cognitively intact and required extensive assistance of 2 staff members for all care except eating. The MDS documented she had the presence of pain and utilized PRN pain medications.</p> <p>A Pain Evaluation, dated 8/23/18, documented Resident #11 did not have pain at the time of the evaluation. The evaluation did not document an acceptable pain level for Resident #11.</p> <p>Resident #11's Physician Orders included:</p> <ul style="list-style-type: none"> <li>- Norco 7.5-325 mg 1 tablet every 6 hours PRN for pain, ordered 12/20/17.</li> <li>- Tramadol 50 mg every 6 hours PRN for pain, ordered 12/20/17.</li> <li>- Tylenol two 325 mg tablets every 4 hours PRN for pain, ordered 12/20/17.</li> <li>- Norco 7.5-325 mg 1 tablet at bedtime for pain, ordered 6/22/18.</li> </ul> <p>Resident #11's PRN pain medication orders did not provide direction to the nursing staff on which medication to administer according to Resident #11's pain level.</p> <p>The care plan area addressing Resident #11's pain, undated, documented Resident #11 had frequent pain which affected her sleep and activity level. The care plan documented Resident #11 was able to verbalize her pain and staff were to offer non-pharmacological interventions prior to pain medications.</p>	F 697	<p>intervention. All residents with prn pain medications will have a request sent to their physicians to receive an order that will provide direction to the nursing staff of which pain medication is to be administered for the resident's level of pain, this order will be directly tied to the standardized pain scale used in the facility.</p> <p>3. An in-service education program will be conducted on November 6 and 8, 2018 by the DON and the Administrator with all direct staff addressing the importance of pain management documentation. Nursing staff will be in-serviced concerning prn pain medications and treating to the pain scale.</p> <p>4. The DON, or designee, will conduct a random audit of five (5) residents weekly for four (4) consecutive weeks. These residents will be assessed and a record review will be done for pain management documentation as well as the medication to be given per the standardized pain scale. Findings of this audit will be monitored at the monthly Quality Assurance meeting until such time consistent substantial compliance has been met.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135064</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/28/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COUNTRYSIDE CARE &amp; REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1224 EIGHTH STREET RUPERT, ID 83350</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 697	<p>Continued From page 25</p> <p>Resident #11's MAR from 9/1/18 through 9/28/18, documented staff routinely administered her scheduled Norco for pain. The effectiveness of the pain medication was not monitored on the MAR.</p> <p>Resident #11's 9/1/18 through 9/28/18 MAR documented she was administered her PRN pain medications on the following dates:</p> <ul style="list-style-type: none"> <li>* Norco - 9/8/18</li> <li>* Tylenol - 9/2/18, 9/3/18, 9/11/18, 9/13/18, 9/22/18, and 9/23/18.</li> <li>* Tramadol - once on 9/2/18 - 9/6/18, 9/8/18, 9/14/18 - 9/16/18, 9/18/18, 9/21/18, 9/22/18, and 9/27/18, twice on 9/1/18, 9/7/18, 9/9/18, 9/10/18, 9/17/18, 9/20/18, 9/23/18 - 9/26/18, and three times on 9/12/18.</li> </ul> <p>Resident #11's Nursing Progress Notes documented she complained of pain and PRN pain medications were administered and were effective on 9/13/18, 9/17/18, and 9/18/18. Resident #11's MAR and nursing progress notes did not document clinical justification of why the medication was administered or monitoring for the effectiveness of the medication after it was administered.</p> <p>On 9/24/18 at 4:12 PM, Resident #11 stated her pain was not managed well at the current time. Resident #11 stated a few days ago she hurt her right ankle when it was bumped into the chair leg. Resident #11 stated the staff offered her pain medications only when she requested them. Resident #11 stated she experienced more pain when she woke up in the morning from laying in one position at night. Resident #11 stated staff</p>	F 697			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135064</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/28/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COUNTRYSIDE CARE &amp; REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1224 EIGHTH STREET RUPERT, ID 83350</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 697	<p>Continued From page 26</p> <p>offered to reposition her, but she would decline because of pain and she did not want to be woken up at night unless she called for assistance to use the bathroom.</p> <p>On 9/25/18 at 9:16 AM, Resident #11 was observed complaining of pain in her right ankle.</p> <p>On 9/26/18 at 7:32 AM, Resident #11 was observed as her call light was answered by a CNA #1 Resident #11 stated to CNA #1 she has to use the bathroom, and her hips "really" hurt. Resident #11 stated she needed a pain pill. CNA #1 was observed notifying LPN #4 about Resident #11's pain and her request for a pain pill. CNA #1 stated "[Resident #11] said her hips hurt and she needs a pain pill."</p> <p>On 9/26/18 at 7:38 AM, CNA #1 and CNA #2 were observed as they assisted Resident #11 with changing her clothes before they assisted her out of bed and onto the commode. As CNA #1 and CNA #2 were placing socks onto Residents #11's feet, she complained of her right ankle and her hips hurting "extremely" bad. CNA #1 attempted to place her hand at the base of Resident #11's right ankle and Resident #11 cried out, "Careful with that leg. Ow, ow, ow, don't grab the leg there. You can't leave me here for 12 hours without moving me and not expect me to be in pain." CNA #1 placed Resident #11's leg on the bed and asked how she would like her to put her sock on and Resident #11 stated, "Oh I don't know I guess it will just hurt." Resident #11's right ankle appeared to be slightly swollen and had a slight reddened area over her ankle bone. Resident #11 stated her ankle did not look bruised, but it hurt like it was. CNA #1 and CNA</p>	F 697			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135064</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/28/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COUNTRYSIDE CARE &amp; REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1224 EIGHTH STREET RUPERT, ID 83350</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 697	<p>Continued From page 27</p> <p>#2 completed assisting Resident #11 with changing her clothes and placed a Hoyer sling under her on the bed. While they were placing the Hoyer sling under her they rolled her from her left hip to her right hip and Resident #11 complained of her hips hurting.</p> <p>On 9/26/18 at 7:43 AM, CNA #1 and CNA #2 were observed as they assisted Resident #11 onto the commode. Resident #11 asked CNA #1 and CNA #2 for a pain pill. CNA #1 stated she told the nurse already about her request.</p> <p>On 9/26/18 at 7:45 AM, Resident #11's call light was activated letting staff know she needed assistance off the commode.</p> <p>On 9/26/18 at 7:46 AM, LPN #4 was observed as she provided a pain pill. LPN #4 told Resident #11 she had her "pain pill." Resident #11 asked the nurse what the pill was, and the nurse responded, "Your pain pill." Resident #11 wanted to know which type of pain pill was being provided, and the nurse told her it was Tramadol.</p> <p>On 9/26/18 at 7:51 AM, Resident #11's call light was answered by CNA #1 and CNA #3 to assist Resident #11 off of the commode. Resident #11 was vocal with the aides about her right leg and to please not touch her leg down there while they laid her on the bed to finish assisting her with her morning cares.</p> <p>On 9/26/18 at 11:10 AM, Resident #11 stated the pain medication she was provided was not always effective. Resident #11 stated some staff would provide her with pain medications and she could not receive more medications until the next</p>	F 697			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135064</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/28/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COUNTRYSIDE CARE &amp; REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1224 EIGHTH STREET RUPERT, ID 83350</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 697	<p>Continued From page 28</p> <p>allowed time. Resident #11 stated she was aware of an order for PRN Tylenol and Tramadol. Resident #11 stated staff had not asked her to rate her pain prior to providing pain medications.</p> <p>On 9/27/18 at 11:31 AM, the DON stated she thought Resident #11 requested which type of PRN pain medication to provide. The DON stated she was unaware the staff was not consistently monitoring residents for the effectiveness of the pain medications or utilizing a pain scale to determine which medication to provide.</p> <p>2. Resident #21 was readmitted to the facility on 12/13/17, with diagnoses which included restless leg syndrome, fatigue, and hemiplegia.</p> <p>A quarterly MDS assessment, dated 7/3/18, documented Resident #21 was cognitively intact and required extensive assistance of 1-2 staff members for all care except eating. The MDS documented she had the presence of pain almost constantly which interfered with her sleep.</p> <p>A Pain Evaluation, dated 7/30/18, documented Resident #21 did not have pain at the time of the evaluation and utilized Tylenol PRN to control the pain. The evaluation did not document an acceptable pain level for Resident #21.</p> <p>Resident #21's Physician Orders included:</p> <ul style="list-style-type: none"> <li>- Tylenol 500 mg 1-2 tablets every 6 hours PRN for pain, ordered 12/13/17.</li> <li>- Norco 5-325 mg 1-2 tablets every 4 hours PRN for pain, ordered 8/13/18.</li> </ul> <p>Resident #21's PRN pain medication orders did</p>	F 697			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135064</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/28/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COUNTRYSIDE CARE &amp; REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1224 EIGHTH STREET RUPERT, ID 83350</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 697	<p>Continued From page 29</p> <p>not provide direction to the nursing staff of which medication to administer for Resident #21's pain level.</p> <p>The care plan area addressing Resident #21's pain, undated, documented Resident #21 had frequent pain from a stroke which affected her sleep and activity level. The care plan documented she experienced frequent headaches, restless leg syndrome, and bilateral leg pain. The care plan documented Resident #21 was able to verbalize her pain and staff were to offer non-pharmacological interventions prior to pain medications.</p> <p>Resident #21's 9/1/18 through 9/28/18 MAR documented she was administered her PRN pain medications on the following dates:</p> <p>* Norco - once on 9/1/18, 9/2/18, 9/3/18, 9/18/18, and 9/26/18 and twice on 9/21/18. * Tylenol - once on 9/10/18, 9/11/18, 9/12/18, 9/20/18, 9/21/18, 9/24/18, and 9/25/18.</p> <p>Resident #21's Nursing Progress Notes documented she complained of pain and a PRN pain medication was administered and was effective on 9/11/18. Resident #21's MAR and Nursing Progress Notes did not document further clinical justification of why the medication was administered or monitoring for the effectiveness of the medication after it was administered.</p> <p>On 9/25/18 at 9:39 AM, Resident #21 stated she could not get comfortable in her recliner chair due to pain in her back.</p> <p>On 9/25/18 at 2:47 PM, Resident #21 stated her</p>	F 697			

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

PRINTED: 01/11/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135064</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/28/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COUNTRYSIDE CARE &amp; REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1224 EIGHTH STREET RUPERT, ID 83350</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 697	Continued From page 30 bones were hurting in her back. Resident #21 stated the physician had prescribed her Norco and Tylenol for her pain and she did not like requesting them until she could not stand the pain anymore. Resident #21 stated staff did not ask her which type of pain pill she wanted, they would provide her a pain pill and she would accept, and it usually would help. Resident #21 stated if she asked for an ice pack or a hot compress the staff would provide one to assist with pain relief.	F 697			
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5)  §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.  §483.45(c)(2) This review must include a review of the resident's medical chart.  §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a	F 756		11/16/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135064</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/28/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COUNTRYSIDE CARE &amp; REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1224 EIGHTH STREET RUPERT, ID 83350</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 756	<p>Continued From page 31</p> <p>separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.</p> <p>§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interview and record review, it was determined the facility failed to ensure the pharmacy reported medication irregularities related to PRN psychotropic medications. This was true for 3 of 5 residents (#7, #11, and #23) whose monthly MRRs (Medication Regime Review) were reviewed. This failure created the potential for harm when residents psychotropic PRN medications were not reviewed as part of the MRR. Findings include:</p> <p>The monthly MRRs did not identify PRN psychotropic medications were limited to 14 days and were renewed by the physician after an evaluation of the resident to assess if there was a continued need. Examples include:</p>	F 756	<p>1. A review of the medication regimen and identified irregularities will be conducted by the DON for resident <input type="checkbox"/>s #7, #11, #23. Irregularities will be addressed and responses documented. The physician will be notified for the irregularities requiring MD notification.</p> <p>2. The facility has determined that all residents have the potential to be affected.</p> <p>Resident records will be reviewed to identify any irregularities which will be addressed, documented and the physician will be notified.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135064</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/28/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COUNTRYSIDE CARE &amp; REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1224 EIGHTH STREET RUPERT, ID 83350</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 756	<p>Continued From page 32</p> <p>a. Resident #23 was readmitted to the facility on 7/26/16, with diagnoses which included anxiety disorder, mood disorder, and insomnia.</p> <p>A quarterly MDS assessment, dated 8/21/18, documented Resident #23 was cognitively intact and had minimal signs and symptoms of depression. The MDS documented she had no behaviors.</p> <p>Resident #23's Physician Orders included Ativan 0.5 mg three times a day PRN for anxiety, ordered 5/11/18.</p> <p>Resident #23's 5/1/18 through 9/28/18 MAR documented she was administered her PRN Ativan on 5/11/18 and 7/4/18.</p> <p>The March 2018 through August 2018 monthly MRRs did not include identification of irregularities regarding Resident #23's PRN Ativan, a psychotropic medication.</p> <p>b. Resident #7 was admitted to the facility on 12/13/17, with diagnoses which included anxiety disorder, depression, and dementia with behavioral disturbances.</p> <p>A quarterly MDS assessment, dated 8/21/18, documented Resident #7 was severely cognitively impaired and had mild signs and symptoms of depression. The MDS documented she had no behaviors.</p> <p>Resident #7's Physician Orders included Ativan 0.5 mg every 8 hours PRN for anxiety, ordered 12/13/17.</p>	F 756	<p>3.A facility Policy regarding the timely review and action taken on identified medication irregularities as a result of the monthly MRR was developed on 10-29-18 by the facility Administrator. The DON will review the guidelines with the nursing staff on November 6 &amp; 8 2018.The Pharmacist will review all of the prn psychoactive medications and send notices to the physicians to clarify the prn medication orders.</p> <p>4. The DON and the Pharmacist,will address any irregularities identified by the medication regimen review within one week of receipt of the report. Documentation will be provided of action taken for each irregularity noted. The DON will review the documentation for ( 3) months to ensure compliance.</p> <p>Findings of this audit will be monitored at the monthly Quality Assurance meeting until such time consistent substantial compliance has been met.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135064</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/28/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COUNTRYSIDE CARE &amp; REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1224 EIGHTH STREET RUPERT, ID 83350</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 756	Continued From page 33  Resident #7's 9/1/18 through 9/28/18 MAR documented she was administered her PRN Ativan once on 9/1/18, 9/8/18, 9/10/18-9/12/18, 9/15/18, 9/21/18, 9/22/18, and 9/24/18-9/26/18.  The March 2018 through August 2018 monthly MRRs did not include identification of irregularities regarding Resident #7's PRN Ativan, a psychotropic medication.  c. Resident #11 was readmitted to the facility on 12/20/17, with diagnoses which included anxiety disorder.  A quarterly MDS assessment, dated 8/21/18, documented Resident #11 was cognitively intact and had no signs and symptoms of depression. The MDS documented she had no behaviors.  Resident #11's Physician Orders included Xanax 0.25 mg every 6 hours PRN for shaking and anxiety, ordered 4/13/18.  Resident #11's 9/1/18 through 9/28/18 MAR documented she was administered her PRN Xanax on 9/5/18, 9/11/18, 9/14/18, 9/15/18, 9/18/18, 9/22/18, and 9/25/18.  The March 2018 through August 2018 monthly MRRs did not include identification of irregularities regarding Resident #11's PRN Xanax, a psychotropic medication.  On 9/27/18 at 11:27 AM, The DON stated she was unaware of the 14 day restrictions with the PRN psychotropic medications and would review the regulation.	F 756			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135064</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/28/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COUNTRYSIDE CARE &amp; REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1224 EIGHTH STREET RUPERT, ID 83350</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 756	Continued From page 34	F 756			
F 758 SS=D	<p>On 9/27/18 at 11:52 AM, the Pharmacist stated they participated in the psychotropic drug committee and reviewed residents' medications quarterly. The Pharmacist stated they also reviewed residents' medications monthly during an MRR. The Pharmacist stated they would review PRN psychotropic medications and would make recommendations to discontinue the medication if the resident was not utilizing the drug. The Pharmacist stated he was unaware of the 14 day restriction on PRN psychotropic medications and the need for the physician to evaluate the resident for continued use.</p> <p>Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5)</p> <p>§483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that---</p> <p>§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;</p> <p>§483.45(e)(2) Residents who use psychotropic</p>	F 758		11/16/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135064</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/28/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COUNTRYSIDE CARE &amp; REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1224 EIGHTH STREET RUPERT, ID 83350</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 758	<p>Continued From page 35</p> <p>drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;</p> <p>§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and</p> <p>§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.</p> <p>§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on staff and resident interview, record review, and facility policy review, it was determined the facility failed to a) Monitor specific behaviors for residents receiving psychoactive medications, b) provided an appropriate order for a PRN anti-anxiety medication, and c) provided adequate information on consent about the black box warnings of medications. This was true for 3 of 5 residents (#7, #11, and #23) reviewed for unnecessary medications. This deficient practice had the potential for harm should residents</p>	F 758	<p>1. Resident #23's record was reviewed and her care plan was changed to address behavior monitoring for all behaviors. Care plan to include anxiety and sleep and how it presents itself as well as behavior sheets for these signs and symptoms. Her physician was faxed on 10-29-18 to clarify the depression diagnosis. A fax will be sent to her physician to address the medication irregularity of the Ativan. Behavior</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135064</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/28/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COUNTRYSIDE CARE &amp; REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1224 EIGHTH STREET RUPERT, ID 83350</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 758	<p>Continued From page 36</p> <p>receive psychotropic medications that were unwarranted, not adequately monitored, and used for excessive duration. Findings include:</p> <p>The facility's psychoactive medications policy and procedures, undated, documented psychoactive medications would be reviewed by the psychotropic medication committee to address reductions, effectiveness and side effects. An assessment would be done to determine the underlying cause of the behavioral symptoms. The care plan would be revised to describe the signs and symptoms of the behavior, to provide instruction to monitor for signs and symptoms, instruction on how to manage the behaviors should they occur, and to provide non-pharmacological interventions to use prior to administration of prn medications. This policy was not followed.</p> <p>a. Resident #23 was admitted to the facility on 7/22/16, with diagnoses which included anxiety disorder, mood disorder, and insomnia. (Resident #23 did not have a diagnosis for depression.)</p> <p>A quarterly MDS assessment, dated 8/21/18, documented Resident #23 was cognitively intact and had minimal signs and symptoms of depression. The MDS documented she had no behaviors.</p> <p>Resident #23's History and Physical (H&amp;P), dated 3/18/15, documented she had a mood disorder. The H&amp;P documented Resident #23 was on Zyprexa and the plan was to wean her down on the medication because she was on Cymbalta as well.</p>	F 758	<p>monitoring sheets were created to address all behaviors. A PRN medication administration monitor form will be created to track why the medication was given, if it was effective and if any adverse side effects were noted. New consent forms will be completed to show correct black box warnings. The Psychotropic Drug Committee will evaluate for GDR on 11-5-18 to include the number of episodes for each behavior. A GDR was done on 9-22-15; it was increased again on 10-15-15 due to failed reduction. The Psychotropic Drug Committee will be educated on what should be included in GDR documentation e.g. behaviors, episodes and number of doses given.</p> <p>Resident #7's record was reviewed and the care plan for depression was updated to include the side effects of her depression medication. A behavior monitor will be created to monitor for increased signs and symptoms of depression. The care plan for anxiety will be updated to include side effects of her anxiety medication. A behavior monitor will be created to monitor for increased signs and symptoms of anxiety. A pain monitoring tool will be created to monitor pain, effectiveness of pain medication, signs and symptoms of pain and side effects of pain medication. A fax will be sent to the physician to address the medication irregularity of the Ativan. A behavior monitoring sheet will be created to address all behaviors. A PRN</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135064</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/28/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COUNTRYSIDE CARE &amp; REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1224 EIGHTH STREET RUPERT, ID 83350</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 758	<p>Continued From page 37</p> <p>Resident #23's September 2018 Physician Orders included:</p> <ul style="list-style-type: none"> <li>- Zyprexa 15 mg at bedtime for mood disorder, ordered 5/11/18.</li> <li>- Cymbalta 30 mg in the evening for depression, ordered 5/11/18.</li> <li>- Cymbalta 60 mg in the morning for depression, ordered 5/11/18.</li> <li>- Ativan 0.5 mg at bedtime for anxiety and sleep, ordered 5/11/18.</li> <li>- Ativan 0.5 mg three times a day PRN for anxiety, ordered 5/11/18.</li> </ul> <p>Resident #23's medications were not changed from 2015 when the physician documented the plan was to "wean" her Zyprexa down. Resident #23 remained on Zyprexa and Cymbalta in 2018.</p> <p>i. Resident #23's care plan issues as follows:</p> <p>The care plan area addressing Resident #23's behaviors, undated, documented Resident #23 would hide the remote in public places, try to control other residents, and made false accusations. The care plan did not include documentation staff monitored Resident #23 for these behaviors.</p> <p>The care plan area addressing Resident #23's depression, undated, documented Resident #23 had the potential for increased depression as evidenced by a decrease in social interaction and appetite and complaining about where she is living. The care plan documented staff monitored Resident #23 for side effects of the medications and for increased signs and symptoms of depression. Resident #23 did not have a</p>	F 758	<p>medication administration monitor form will be created to track why the medication was given, if it was effective and if any adverse side effects were noted. New consent form for the Ativan will be completed to address black box warnings. The Psychotropic Drug Committee will evaluate for GDR on 11-5-18 to include specific behaviors, number of episodes of anxiety and identify she is on a PRN psychotropic medication.</p> <p>Resident #11's record was reviewed and a fax will be sent to the physician to address the medication irregularity of the Alprazolam. A behavior monitoring sheet will be created to address all resident specific behaviors. A PRN medication administration monitor form will be created to track why the medication was given, if it was effective and if any adverse side effects were noted. New consent form for the Alprazolam will be completed to address black box warnings. The Psychotropic Drug Committee will evaluate for GDR on 11-5-18 to include specific behaviors, number of episodes of anxiety.</p> <p>2. The facility has determined that all residents have the potential to be affected.</p> <p>All resident care plans will be reviewed for resident specific behaviors and a behavior monitoring sheet will be created. All care plans will have adverse side effects of psychotropic medication added.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135064</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/28/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COUNTRYSIDE CARE &amp; REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1224 EIGHTH STREET RUPERT, ID 83350</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 758	<p>Continued From page 38</p> <p>diagnosis of depression documented in her record.</p> <p>The care plan area addressing Resident #23's Zyprexa, undated, documented Resident #23 had a diagnosis of mood disorder as evidenced by complaining about federal regulation, happy one day and sad the next, did not think she needed to follow safety rules, complaining about staff, and "speeds" her wheelchair into things and where other residents were residing. The care plan documented staff were to monitor Resident #23 for these behaviors and side effects of the medications.</p> <p>Resident #23 did not have a care plan for her anxiety/sleep.</p> <p>ii. The facility was not monitoring Resident #23 for resident specific behaviors identified on her care plan. Examples include:</p> <p>Resident #23's September 2018 Behavior Monitoring flowsheet documented the following behaviors the facility was monitoring for:</p> <ul style="list-style-type: none"> <li>- Physical aggression</li> <li>- Verbal aggression</li> <li>- Pacing, rummaging, disrobing, smearing food or bodily waste</li> <li>- wandering</li> </ul> <p>Resident #23 did not have any behaviors above documented for the month of September 2018.</p> <p>Resident #23's identified behaviors of happy one day and sad the next, did not think she needed to follow safety rules, complaining about staff, and "speeds" her wheelchair into things and where</p>	F 758	<p>All residents who have medication irregularities will have a fax sent to their physician to address the irregularity. All residents who are on PRN medications will have a medication administration monitor form to track why the medication was given, if it was effective and if any adverse side effects were noted. New consent forms will be issued to address black box warnings. All residents who have a psychotropic drug medication will be reviewed for GDR on 11-5-18 which will include documentation of specific behaviors, number of episode, and the correct medication identified. All residents who receive a PRN pain medication will have a pain monitoring tool to monitor pain, effectiveness of pain medication, signs and symptoms of pain and side effects of pain medication.</p> <p>3. An in-service education program will be conducted on November 6 and 8, 2018 by the DON and the Administrator with all direct staff addressing the importance of documenting PRN pain medications, side effects of medication and effectiveness. Behavior monitoring and black box warnings. The Psychotropic Drug Committee will receive education prior to Nov. 5, 2018 concerning documentation of specific behaviors, number of episode, and the correct medication identified.</p> <p>4. The DON, or designee, will conduct a random audit of eight (8) residents weekly for four (4) consecutive weeks. These</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135064</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/28/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COUNTRYSIDE CARE &amp; REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1224 EIGHTH STREET RUPERT, ID 83350</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 758	<p>Continued From page 39</p> <p>other residents were residing were not being monitored. The facility had not identified how Resident #23's anxiety presented or what signs and symptoms staff needed to observe her for.</p> <p>iii. Resident #23 was provided medications without adequate monitoring for side effects, the clinical indication, and effectiveness of the medication. Examples include:</p> <p>Resident #23's September 2018 MAR documented she was administered her scheduled Zyprexa, Cymbalta, and Ativan per her physician's orders.</p> <p>Resident #23's 5/1/18 through 9/28/18 MAR documented she was administered PRN Ativan on 5/11/18 and 7/4/18. Resident #23's MAR and nursing progress notes did not document the clinical indication of why the medication was administered or monitor for the effectiveness of the medication after it was administered.</p> <p>Resident #23's clinical record did not include documentation staff was monitoring her for potential adverse side effects of the medication. Resident #23's record did not include behavior monitoring for sleep during all shifts for Ativan, which was indicated for sleep and anxiety.</p> <p>iv. Consents did not contain black box warnings. Examples included:</p> <p>- A Psychoactive Medication Consent, dated 5/10/18, documented Resident #23 received Ativan 0.5 mg at bedtime and three times a day PRN. The consent documented there was no black box warning for this medication. According</p>	F 758	<p>residents will be assessed and a record review will be done for documentation of specific behaviors, number of episode, and the correct medication identified.</p> <p>Findings of this audit will be monitored at the monthly Quality Assurance meeting until such time consistent substantial compliance has been met.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135064</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/28/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COUNTRYSIDE CARE &amp; REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1224 EIGHTH STREET RUPERT, ID 83350</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 758	<p>Continued From page 40</p> <p>to the Nursing 2018 Drug Handbook there is a black box warning for this medication cautioning with the use of opioids which "may cause sedation and death" and to use this medication "cautiously in the elderly."</p> <p>- A Psychoactive Medication Consent, dated 5/10/18, documented Resident #23 received Cymbalta 60 mg in the morning and 30 mg at night. The consent documented there was no black box warning for this medication. According to the Nursing 2018 Drug Handbook there is a black box warning for this medication cautioning that increased "depression" and "suicidal thoughts or behaviors" could occur.</p> <p>v. Resident #23's GDR (gradual dose reduction) did not review specific behaviors, monitor hours of sleep, or identify she was on a PRN psychotropic medication.</p> <p>Resident #23's Quarterly Psychotropic Drug Committee Update, dated 4/19/18, documented Resident #23 should remain on Ativan, Cymbalta, and Zyprexa because Resident #23 required the use of 6 administrations of PRN Ativan and her depression score on her most recent MDS was a 2 (A score of 2 indicates minimal signs and symptoms of depression.) The update documented Resident #23 voiced concerns of feeling down or depressed 2-6 days out of 14. The update also documented Resident #23 did not want to change her medications at this time and the committee did not make a recommendation for a GDR of the medications.</p> <p>The Quarterly Psychotropic Drug Committee Update did not evaluate Resident #23's sleeping</p>	F 758			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135064</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/28/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COUNTRYSIDE CARE &amp; REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1224 EIGHTH STREET RUPERT, ID 83350</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 758	<p>Continued From page 41</p> <p>habits, document how many episodes/behaviors of depression, mood disorder, or anxiety, she had experienced during the look back period, and did not address the 14 day limit with the use of the PRN psychotropic medication.</p> <p>b. Resident #7 was admitted to the facility on 12/13/17, with diagnoses which included anxiety disorder, depression, and dementia with behavioral disturbances.</p> <p>A quarterly MDS assessment, dated 8/21/18, documented Resident #7 was severely cognitively impaired and had mild signs and symptoms of depression. The MDS documented she had no behaviors.</p> <p>Resident #7's Physician Orders included:</p> <ul style="list-style-type: none"> <li>- Celexa 20 mg in the morning for depression, ordered 12/13/17.</li> <li>- Ativan 0.5 mg every 8 hours PRN for anxiety, ordered 12/13/17.</li> <li>- Norco 7.5-325 mg 1-2 tablets every 4 hours as needed for pain, ordered 12/13/17.</li> </ul> <p>The care plan area addressing Resident #7's risk for alterations in cognition, undated, documented Resident #7 preferred to stay in her room most days and was forgetful and confused at times. The care plan documented staff were to encourage Resident #7 to leave her room and staff were to administer Resident #7's antidepressant medication as ordered.</p> <p>The care plan area addressing Resident #7's depression, undated, documented Resident #7 had the potential for increased depression as</p>	F 758			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135064</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/28/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COUNTRYSIDE CARE &amp; REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1224 EIGHTH STREET RUPERT, ID 83350</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 758	<p>Continued From page 42</p> <p>evidenced by crying, tearfulness, withdrawal, change in sleep patterns, changes in appetite, and negative statements. The care plan documented the staff were to monitor Resident #7 for increased signs and symptoms of depression. The side effects of her depression medication were not included in her care plan.</p> <p>The care plan area addressing Resident #7's anxiety, undated, documented Resident #7 had anxiety related to "pain and restlessness." The care plan documented staff were to observe Resident #7 for increased restlessness, agitation, and confusion. The care plan documented staff were to offer Resident #7 comforts to aid in sleep and relaxation. The care plan documented staff were to monitor Resident #7 for these behaviors and side effects of medications.</p> <p>The care plan area addressing Resident #7's bladder and bowel, undated, documented Resident #7 had anxiety with transfers, and "getting out of bed due to pain."</p> <p>The care plan area addressing Resident #7's pain, undated, documented Resident #7's pain increased her anxiety and caused tearfulness. The care plan documented Resident #7 worried about things and needed anti-anxiety medications to sleep.</p> <p>i. The facility was not monitoring Resident #7 for resident specific behaviors identified on her care plan. Examples include:</p> <p>The September 2018 Behavior Monitoring flowsheet documented Resident #7 experienced the following behaviors:</p>	F 758			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135064</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/28/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COUNTRYSIDE CARE &amp; REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1224 EIGHTH STREET RUPERT, ID 83350</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 758	<p>Continued From page 43</p> <ul style="list-style-type: none"> <li>- Physical aggression -1 episode</li> <li>- Verbal aggression -9 episodes</li> <li>- Pacing, rummaging, disrobing, smearing food or bodily waste - 2 episodes</li> <li>- Wandering - 1 episode</li> </ul> <p>Resident #7's identified behaviors of anxiety, depression, restlessness, agitation, confusion, crying, tearfulness, changes in sleep pattern, self-isolation, making negative statements, and pain were not being monitored in September 2018.</p> <p>ii. Resident #7 was provided medications without adequate monitoring of side effects, clinical justification, and effectiveness of the medications. Examples include:</p> <p>Resident #7's September 2018 MAR documented she was administered her scheduled Celexa per her physician's orders.</p> <p>Resident #7's 9/1/18 through 9/28/18 MAR documented she was administered PRN Ativan once on 9/1/18, 9/8/18, 9/10/18-9/12/18, 9/15/18, 9/21/18, 9/22/18, and 9/24/18-9/26/18. The staff documented a rationale of "crying" for the administration of the Ativan on 9/1/18, 9/21/18, 9/22/18, and 9/26/18. Resident #7's MAR and nursing progress notes did not document further clinical justification of why the medication was administered. There was no documentation for the effectiveness of the medication after it was administered.</p> <p>Resident #7's care plan documented pain caused her to have anxiety. The MAR documented</p>	F 758			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135064</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/28/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COUNTRYSIDE CARE &amp; REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1224 EIGHTH STREET RUPERT, ID 83350</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 758	<p>Continued From page 44</p> <p>Resident #7 was administered 2 tablets of Norco within 5 minutes of the Ativan's administrations on 9/1/18, 9/8/18, 9/10/18-9/12/18, 9/15/18, 9/21/18, 9/22/18, and 9/24/18-9/26/18, it was unclear if Resident #7 was anxious due to pain or anxiety. The staff did not provide adequate time for the pain medication administered or the anti-anxiety medication administered to take effect. According to the Nursing 2018 Drug Handbook Ativan and Norco's side effects include sedation and drowsiness.</p> <p>Resident #7's clinical record did not include documentation staff were monitoring her for potential adverse side effects of the Ativan on the MAR, or in the progress notes. Resident #7's record did not contain behavior monitors for sleep during all shift due to the identified behavior of "changes in sleep patterns."</p> <p>iii. Consents did not contain black box warnings. Examples included:</p> <p>A Psychoactive Medication Consent, dated 5/8/18, documented Resident #7 received Ativan 0.5 mg every 8 hours PRN. The consent documented there was no black box warning for this medication. According to the Nursing 2018 Drug Handbook there is a black box warning for this medication cautioning with the use of opioids which "may cause sedation and death" and to use this medication "cautiously in the elderly."</p> <p>iv. Resident #7's GDR did not review specific behaviors or identify she was on a PRN psychotropic medication.</p> <p>Resident #7's Quarterly Psychotropic Drug</p>	F 758			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135064</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/28/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COUNTRYSIDE CARE &amp; REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1224 EIGHTH STREET RUPERT, ID 83350</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 758	<p>Continued From page 45</p> <p>Committee Update, dated 7/25/18, documented Resident #7 should remain on Ativan and Celexa related to Resident #7's frequent administrations of PRN Ativan. The update documented Resident #7 was "totally dependent" on staff for all cares and left her room if assisted by staff. The update documented Resident #7 preferred to stay in her room, and in bed most days. The update documented her depression score was not calculated on her last MDS due to Resident #7's impaired cognition. The update documented the committee recommended a GDR of Resident #7's Celexa on 4/30/18 and again on 6/27/18. Her physician documented a decrease could cause worsening depression and anxiety.</p> <p>The update did not evaluate Resident #7 for how many episodes/behaviors of depression and or anxiety she experienced during the look back period and did not address the 14 day limit with the use of the PRN psychotropic medication.</p> <p>c. Resident #11 was readmitted to the facility on 12/20/17, with diagnoses which included anxiety disorder.</p> <p>A quarterly MDS assessment, dated 8/21/18, documented Resident #11 was cognitively intact and had no signs and symptoms of depression. The MDS documented she had no behaviors.</p> <p>Resident #11's Physician Orders, dated 4/13/18, included Xanax 0.25 mg every 6 hours PRN for shaking and anxiety.</p> <p>The care plan area addressing Resident #11's anxiety, undated, documented Resident #11 had alterations in mood related to anxiety disorder.</p>	F 758			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135064</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/28/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COUNTRYSIDE CARE &amp; REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1224 EIGHTH STREET RUPERT, ID 83350</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 758	<p>Continued From page 46</p> <p>The care plan documented Resident #11 experienced uneasy feelings, shaking, speaking negatively, her mind "not shutting off," and she was unable to sit still. The care plan documented staff were to monitor Resident #11 for these behaviors and side effects of the Xanax.</p> <p>i. The facility was not monitoring Resident #11 for resident specific behaviors identified on her care plan. Examples include:</p> <p>The September 2018 Behavior Monitoring flowsheet documented Resident #11 experienced the following behaviors:</p> <ul style="list-style-type: none"> <li>- Physical aggression -0 episode</li> <li>- Verbal aggression -7 episodes</li> <li>- Pacing, rummaging, disrobing, smearing food or bodily waste - 0 episodes</li> <li>- Wandering - 0 episode</li> </ul> <p>Resident #11's identified behaviors from her care plan of uneasy feelings, shaking, speaking negatively, her mind not shutting off, and unable to sit still were not being monitored.</p> <p>ii. Resident #11 was provided medications without adequate monitoring of side effects, clinical justification, and effectiveness of the medication</p> <p>Resident #11's 9/1/18 through 9/28/18 MAR documented she was administered her PRN Xanax on 9/5/18, 9/11/18, 9/14/18, 9/15/18, 9/18/18, 9/22/18, and 9/25/18. The staff documented a rationale the Resident #19 requested for anxiety for the administration of the Xanax on 9/5/18. Resident #11's MAR and</p>	F 758			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135064</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/28/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COUNTRYSIDE CARE &amp; REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1224 EIGHTH STREET RUPERT, ID 83350</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 758	<p>Continued From page 47</p> <p>nursing progress notes did not document further clinical justification of why the medication was administered or monitor for the effectiveness of the medication after it was administered.</p> <p>Resident #11's clinical record did not include documentation staff were monitoring her for potential adverse side effects of the Xanax.</p> <p>iii. Consents did not contain black box warnings.</p> <p>A Psychoactive Medication Consent, dated 10/25/17, documented Resident #11 received Xanax 0.25 mg every 6 hours PRN. The consent documented there was no black box warning for this medication. According to the Nursing 2018 Drug Handbook there is a black box warning for this medication cautioning with the use of opioids which "may cause sedation and death" and to use this medication "cautiously in elderly patients."</p> <p>iv. Resident #11's GDR did not review specific behavior or identify she was on a PRN psychotropic medication.</p> <p>Resident #11's Quarterly Psychotropic Drug Committee Update, dated 7/26/18, documented Resident #11 should remain on Xanax related to her 35 administrations of the PRN medication. The update did not included a timeframe of when they looked at Resident #11's PRN Xanax use. The update documented Resident #11 had anxiety over showers and not sitting on the commode correctly. The update committee did not make a recommendation for the physician to consider.</p>	F 758			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135064</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/28/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COUNTRYSIDE CARE &amp; REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1224 EIGHTH STREET RUPERT, ID 83350</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 758	<p>Continued From page 48</p> <p>The update did not evaluate Resident #11 for how many episodes/behaviors of anxiety she experienced during the look back period and did not address the 14 day limit with the use of the PRN psychotropic medication, Xanax.</p> <p>On 9/27/18 at 11:27 AM, the DON stated the consents did not contain black box warnings because the facility understood they were to include black box warnings "only" if the warnings related to increased mortality in the elderly and those with dementia. The DON stated she was not aware of the generic behavior monitoring in place for Resident #7, #11, and #23 that did not match the care plans. The DON stated she was unaware the current computer system did not automatically remind staff to monitor the effectiveness of the PRN psychotropic medications. The DON stated staff should document in a progress note why they provided the PRN psychotropic medication and document the effectiveness. The DON stated she was unaware of the 14 day restriction with PRN psychotropic medications and would review the regulation.</p> <p>On 9/27/18 at 4:16 PM, the LSW stated the behaviors of residents taking psychotropic medications should be resident focused. The LSW stated the care plan, behavior monitoring, and medications should all be related. The LSW stated the current behavior monitors were not resident specific for Resident #7, #11, and #23 and all the behavior monitors in the facility were identical for each resident. The LSW stated she would correct this issue and stated the computer system was new to the staff and she was not aware the behavior monitors were identical.</p>	F 758			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135064</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/28/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COUNTRYSIDE CARE &amp; REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1224 EIGHTH STREET RUPERT, ID 83350</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 761 SS=D	<p>Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)</p> <p>§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.</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: Based on policy review, observation, and staff interview, it was determined the facility failed to ensure medications were secure and inaccessible to unauthorized staff and residents. This failed practice created the potential for harm to a resident if they were to obtain medications which were left unattended and unsecured by staff. Findings include:</p>	F 761	<p>1. LPN #4 and RN#2 were in-serviced by the DON concerning leaving medications on the med cart and not locked away. No residents were affected by this practice.</p> <p>2. The facility has determined that all residents have the potential to be affected.</p>	11/16/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135064</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/28/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COUNTRYSIDE CARE &amp; REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1224 EIGHTH STREET RUPERT, ID 83350</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 761	<p>Continued From page 50</p> <p>The facility's medication security policy and procedure, undated, documented all drugs and biological's stored in the facility should be kept in a secure area, locked when appropriate, and accessible only to authorized staff. A secure area was defined as an area that prevents unauthorized individuals unmonitored access to drugs and biological's.</p> <p>On 9/25/18 at 10:58 AM, LPN #2 was observed administrating medications, including insulin, to residents on the east hall of the facility. The insulin vials were contained in a plastic enclosed container and left unattended on top of the medication cart located at the nurses' station. LPN #2 placed a paper towel over the container. LPN #2 stated she was supposed to lock the insulin and not leave the medication unattended.</p> <p>On 9/26/18 at 7:18 AM, LPN #4 was observed administrating medications, including insulin, to residents on the east hall of the facility. The insulin vials were contained in a plastic enclosed container and left unattended on top of the medication cart located at the nurses' station. LPN #4 stated she knew medications were supposed to be locked away before leaving the cart to administer medications to residents.</p> <p>On 9/27/18 at 4:45 PM, insulin vials enclosed in a plastic container were observed at the east nurses' station behind the counter and unattended by staff at the desk.</p> <p>On 9/27/18 at 5:15 PM, RN #2 was observed administering medications, including insulin, to residents on the east hall of the facility. The insulin vials were contained in a plastic enclosed</p>	F 761	<p>No residents were affected by this practice.</p> <p>3. An in-service education program will be conducted on November 6 and 8, 2018 by the DON and the Administrator with all nursing staff addressing the importance of keeping medications locked in the medication cart when not in use.</p> <p>4. The DON, or designee, will conduct a random audit of four (4) medication passes per week for four (4) consecutive weeks. Findings of this audit will be monitored at the monthly Quality Assurance meeting until such time consistent substantial compliance has been met.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135064</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/28/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COUNTRYSIDE CARE &amp; REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1224 EIGHTH STREET RUPERT, ID 83350</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 761	Continued From page 51 container and left unattended on top of the medication cart located at the nurses' station.  On 9/27/18 at 5:30PM, the DON stated the medications should not be left unattended on the cart or at the nurses' station according to their policy. The DON stated insulin should be secured in the refrigerator.	F 761			
F 803 SS=E	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7)  §483.60(c) Menus and nutritional adequacy. Menus must-  §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.;  §483.60(c)(2) Be prepared in advance;  §483.60(c)(3) Be followed;  §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups;  §483.60(c)(5) Be updated periodically;  §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and  §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced	F 803		11/16/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135064</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/28/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COUNTRYSIDE CARE &amp; REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1224 EIGHTH STREET RUPERT, ID 83350</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 803	<p>Continued From page 52</p> <p>by: Based on observations, review of menus, and resident and staff interviews, the facility failed to ensure menus were updated to reflect the residents' cultural and dietary choices. This affected 8 of 11 (#3, #8, #9, #16, #19, #21, #23, and #28) residents in the group interview, 2 of 12 (#11 and #23) sampled residents and had the potential to affect all residents who dined in the facility. This failed practice had the potential for harm if residents were dissatisfied with their meals or experienced weight loss. Findings include:</p> <p>On 9/24/18 at 3:53 PM, Resident #23 stated she struggled with the food in the facility. Resident #23 stated she would like to follow a vegetarian diet and the facility does not provide options besides meat. Resident #23 stated she chose cereal and skim milk because of the lack of options. Resident #23 also would like other options to drink such as tea and not have to pay for them out of a vending machine.</p> <p>On 9/24/18 at 4:12 PM, Resident #11 stated the food at the facility left something to be desired. Resident #11 stated the option most days was chicken and "guess what chicken." Resident #11 stated sometimes she felt like she would start clucking like a chicken with how much it was served. Resident #11 stated the facility served mashed potatoes frequently and there were not many alternatives. Resident #11 stated she did not know what was being served until the staff came around and announced the meal for the day. Resident #11 stated it would be nice to be able to see a menu to see what was offered.</p>	F 803	<ol style="list-style-type: none"> <li>1. Resident #23 will be offered vegetarian options as well as a variety of drinks of her choice from the dietary department. Resident #11 will be provided food options other than chicken. Resident #s # 3, #8, #9, #16, #19, #21, #23 and #28 will be offered other food options rather than chicken. The corrective action for the facility will also include the affected residents.</li> <li>2. The facility has determined that all residents have the potential to be affected.</li> <li>3. This deficiency will be corrected by procuring balanced, nutritious menus reviewed by a qualified Dietician, which will then be rotated to provide quality foods in conjunction with seasonal changes and increasing variety. These menus will be reviewed and signed by the facility dietitian. Vegetarian options will be made available daily.</li> <li>4. A weekly tray line audit will be performed by the Clinical CDM or FSD to ensure menus are adequate and rotated seasonally. This audit will include: Menu is appealing, colorful, and has good aroma. Menu is balanced and non-repetitive. Correct procedures are followed if menu substitutions are made <input type="checkbox"/> all substitutions are approved by the FSD or Clinical CDM. Standardized recipes are followed for menu preparation. Cook, FSD, or CDM tastes all food items prior to</li> </ol>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135064</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/28/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COUNTRYSIDE CARE &amp; REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1224 EIGHTH STREET RUPERT, ID 83350</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 803	<p>Continued From page 53</p> <p>On 9/25/18 at 10:02 AM, during the resident group interview, Residents #3, #8, #9, #16, #19, #21, #23, and #28 said the food was an issue and had been issue for months. The residents stated the meals came out late at times, there was too much chicken served, and the mashed potatoes tasted like water and was served too often. They said the food lacked flavor and temperatures were not hot enough. Resident #8, #16, #21, #23, and #28, said all of these issues were discussed in previous Resident Council meetings, but the facility had not done enough to look into these concerns. The residents also said the DM would tell residents she had spoken with "corporate" and they were working on the issue, but then nothing was done.</p> <p>The facility's Cycle Menu 2 documented the facility served chicken or turkey 24 out of 48 opportunities as the main dish for lunch or dinner in a four-week period. The menu documented the facility served mashed potatoes 13 out of 48 opportunities for lunch or dinner in a four-week period. A review of the menu found a lack of a vegetarian options on the alternative menus.</p> <p>The facility's Resident Council Notes March 2018 through September 2018 documented the resident had complaints about the food. Examples included:</p> <ul style="list-style-type: none"> <li>* March- CDM stated the facility was "hopefully" getting new menus out next month.</li> <li>* April- The food selection was tiresome.</li> <li>* May- The residents wanted a new food menu. (after June the resident council meetings moved to quarterly meetings.)</li> <li>* September - The residents wanted more variety</li> </ul>	F 803	<p>service to ensure quality. Clinical CDM to attend monthly QA meeting where the weekly tray line audit may be discussed and comments made regarding auditing results. The Administrator or her designee, will do weekly interviews with 4 residents to see if the dietary issues have been resolved. Audit results will be monitored at the monthly Quality Assurance meeting.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135064</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/28/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COUNTRYSIDE CARE &amp; REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1224 EIGHTH STREET RUPERT, ID 83350</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 803	Continued From page 54 on the menu and the times of the meals changed.  On 9/27/18 at 12:56 PM to 1:04 PM, a test tray of chicken and mashed potatoes from the lunch menu was provided to 2 surveyors and the Supervising CDM. The chicken tasted like chicken and the mashed potatoes lacked flavor and tasted watery. The Supervising CDM stated the kitchen had run out of real mashed potatoes and had to make potato substitutes. The Supervising CDM stated she was aware the residents were not happy with the menu however, it was out of her hands because the corporate RD developed the menu and provided it to the facility. The Supervising CDM stated the facility was working on implementing a new menu for about a year and the corporate RD had left the company and the roll out was halted. The Supervising CDM stated she was hopeful the new menu implementation would occur soon. The Supervising CDM stated the facility did not currently provide menus for the residents to view but if the residents would like that was something that could be discussed. The Supervising CDM stated there was not a vegetarian option currently on the menu and she would pass this along to the corporate RD to include into the new menu revision.	F 803			
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)  §483.60(i) Food safety requirements. The facility must -  §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.	F 812		11/16/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135064</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/28/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COUNTRYSIDE CARE &amp; REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1224 EIGHTH STREET RUPERT, ID 83350</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 812	<p>Continued From page 55</p> <p>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.</p> <p>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.</p> <p>(iii) This provision does not preclude residents from consuming foods not procured by the facility.</p> <p>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and staff interview, it was determined the facility failed to ensure food was handled properly and maintained according to safe practices. This was true when Potentially Hazardous Food (PHF) cold food temperatures were not assessed prior to service. The facility failed to ensure measures were in place to prevent possible cross-contamination of dirty to clean areas in the kitchen. These failed practices placed 16 of 16 residents (#2, #4, #5, #6, #8, #9, #11, #13, #14, #15, #19, #21, #23, #29, #83, #84) and the other 17 residents who resided in, and dined in the facility, at risk of adverse health outcomes. Findings include:</p> <p>a. On 9/27/18 at 5:42 PM Cook #2 and Cook #5 were observed during the dish washing process. Cook #2 was observed moving between various tasks such as cleaning out juice machines, assisting on tray line, working on the dirty dish side, and picking up trash. Cook #2 removed a pair of gloves and entered the clean dish side</p>	F 812	<p>1. Resident's #2, #4, #5, #6, #8, #9, #11, #13, #14, #15, #19, #21, #23, #29, #83 and #84 were assessed and no adverse health outcomes were noted.</p> <p>2. The facility has determined that all residents have the potential to be affected. No adverse health outcomes have been noted on any resident.</p> <p>3. Staff in-services will begin in November and continue monthly regarding the deficiency practices by the FSD or Clinical CDM and quarterly for the facility Dietitian. In-services will include: Cross contamination of food, Safe handling of PHF (time/temperature control of PHF), Safe handling of food contact surfaces and proper hand hygiene practices. All food and nutrition staff will be required to complete the Idaho Food Safety Exam.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135064</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/28/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COUNTRYSIDE CARE &amp; REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1224 EIGHTH STREET RUPERT, ID 83350</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 812	<p>Continued From page 56</p> <p>and began putting clean dishes away without washing her hands. Cook #2 asked Cook #5 where the dishes belonged and Cook #5 left the tray line to assist her, Cook #5 entered the clean dish area and began placing dishes away without washing her hands.</p> <p>Cook #1 was the stand in manager while the CDM was out of the facility, and was present during the observation. She stated this was not the correct procedure for handling clean dishware. Cook #1 stated Cook #2 and Cook #5 should have washed their hands before touching the clean dishes.</p> <p>b. The 2017 FDA Food Code, Chapter 3, Part 3-5, Limitation of Growth of Organisms of Public Health Concern, subpart 3-501.12 Time/Temperature Control for Safety Food, Slacking, documented, "(A) Under refrigeration that maintains the food temperature at 5 C (41 F [Fahrenheit]) or less..."</p> <p>On 9/27/18 at 5:40 PM, Cook #4 was observed assessing the temperatures of the milk and the juice in the main kitchen. The milk was assessed to be 32 degrees F and the juices were assessed to be 37 degrees F. The milk and juice were placed in a cart with pudding, applesauce, chopped salad, cold cereal, and other cold food items. The door of the cart was left open.</p> <p>On 9/27/18 at 5:57 PM, Cook #4 and Cook #5 left the main kitchen with two food carts and entered the main dining room to set up for the dinner meal. The dinner meal consisted of the following options: grilled ham and cheese sandwiches, tomato soup, chocolate pudding, chopped salad</p>	F 812	<p>4. In-service notes will be reviewed and monitored at least monthly at the QA meeting by the CDM or FSD. Temperature on food items to be served will be audited weekly by Clinical CDM or FSD to ensure proper time/temperature control of PHF. Temperature on food items to be served will be audited monthly by facility Dietitian to ensure proper time/temperature control of PHF.</p> <p>All audit results will be reviewed by the Quality Committee at the monthly QA meeting.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135064</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/28/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COUNTRYSIDE CARE &amp; REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1224 EIGHTH STREET RUPERT, ID 83350</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 812	<p>Continued From page 57</p> <p>plate, turkey sandwich, vegetable soup, fruited gelatin, milk, and juice.</p> <p>Cook #5 assessed the temperatures of the hot foods for the dinner meal and food items were at the appropriate temperature except for the grilled ham and cheese sandwich. The sandwich was assessed to be at 116 degrees F.</p> <p>Cook #3 arrived to assist Cook #4 and Cook #5 with the dinner meal service. Cook #5 did not assess the temperatures of the cold food items. Cook #4 asked Cook #5 what the temperature of the milk and juice was and Cook #5 stated the milk was 32 degrees F and the juice was 37 degrees F.</p> <p>On 9/27/18 at 6:15 PM, the Temperature Records were reviewed, and the cold food items for dinner were not assessed on a consistent basis. Cook #3, Cook #4, and Cook #5 stated they did not assess the temperatures of the cold food items. Cook #3 stated they were not instructed to do so. Cook #3 was unable to say what a PHF was.</p> <p>The facility's Temperature Record for dinner, Monday 9/24/18 through Thursday 9/27/18, did not include documentation cold food temperatures were assessed.</p> <p>On 9/27/18 at 6:25 PM, Cook #1 stated the cold foods should be less than 41 degrees before service and PHF included items such as pudding or a salad. Cook #1 stated she was aware a resident ordered a chopped salad almost every night and the resident had ordered one that night.</p> <p>On 9/27/18 at 6:46 PM, the Supervising CDM</p>	F 812			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135064</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/28/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COUNTRYSIDE CARE &amp; REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1224 EIGHTH STREET RUPERT, ID 83350</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 812	Continued From page 58 stated the cold foods should be assessed for temperature and the grilled ham and cheese sandwich should not have been served at 116 degrees F without attempting to reheat it. The Supervising CDM stated the temperature of the sandwich should have been at a minimum of 135 degrees F.	F 812			
F 880 SS=D	<p>Infection Prevention &amp; 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</p>	F 880		11/16/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135064</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/28/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COUNTRYSIDE CARE &amp; REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1224 EIGHTH STREET RUPERT, ID 83350</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 880	<p>Continued From page 59</p> <p>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> <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</p>	F 880			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135064</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/28/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COUNTRYSIDE CARE &amp; REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1224 EIGHTH STREET RUPERT, ID 83350</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 880	<p>Continued From page 60</p> <p>by: Based on observation and interview, it was determined the facility failed to ensure the staff consistently followed hand hygiene practices consistent with accepted standards of practice. This was true for 2 of 12 residents (#15 and #23) observed receiving direct resident care by staff. Failure to perform hand hygiene between glove changes during incontinence care, and proper hand washing after incontinence care, created the potential for infections to develop from cross contamination of infection causing organisms. Findings include:</p> <p>According to the Centers for Disease Control and Prevention (CDC), website accessed on 10/18/18, hand hygiene should be performed after removing gloves, after contact with blood, body fluids or excretions, mucous membranes, after contact with inanimate objects in the immediate vicinity of the patient, and if hands will be moving from a contaminated body site to a clean body site during patient care.</p> <p>The CDC also stated "When using alcohol-based hand sanitizer: Put product on hands and rub hands together; Cover all surfaces until hands feel dry; This should take around 20 seconds." "When cleaning your hands with soap and water, wet your hands first with water, apply the amount of product recommended by the manufacture to your hands, and rub your hands together vigorously for at least 15 seconds...rinse...The focus should be on cleaning your hands at the right times."</p> <p>a. On 9/26/18 at 6:49 AM, CNA #1 and CNA #2 assisted Resident #15 with changing his attends,</p>	F 880	<p>1. Resident's #15 and #23 were assessed and have no harm noted as a result of the deficient practice.</p> <p>2. The facility has determined that all residents have the potential to be affected.</p> <p>All residents were assessed and no harm has been noted as a result of the deficient practice.</p> <p>3. CNA #1 was in serviced concerning the proper use of hand hygiene and glove changes to prevent infections. CNA #2 was in serviced concerning the proper use of hand sanitizers, drying time and keeping the hands clean prior to donning new gloves. CNA #2 was also in-serviced concerning proper handling of catheter tubing and catheter bags to prevent infection.</p> <p>An in-service education program will be conducted on November 6 and 8, 2018 by the DON and the Administrator with all direct staff addressing the importance of proper hand hygiene and glove changes before, during and after resident care. Proper use of hand sanitizers</p> <p>4. The DON, or designee, will conduct a random audit of eight (8) CNA's weekly for four (4) consecutive weeks. Findings of this audit will be monitored at the monthly Quality Assurance meeting until such time consistent substantial compliance has been met.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135064</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/28/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COUNTRYSIDE CARE &amp; REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1224 EIGHTH STREET RUPERT, ID 83350</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 880	<p>Continued From page 61</p> <p>placing new clothes on for the day, and assisting him into his wheelchair. CNA #1 placed a pair of gloves on her hands at the start of assisting Resident #15 with cares and she did not remove or change her gloves until she left Resident #15's room to assist another resident.</p> <p>CNA #2 completed assisting Resident #15 with pericare, removed her gloves, applied hand sanitizer, rubbed her hands together for 3 seconds and attempted to apply new gloves with wet hands. CNA #2's gloves broke. Her hands were still wet and she wiped her hands on her pants then placed her hands into the new gloves.</p> <p>Resident #15 was observed to have a catheter bag. Resident #15 was assisted into his wheelchair, and after Resident #15 was sitting in the wheelchair, his catheter bag and tubing was thrown on the floor by CNA #2. The catheter landed between his legs under the wheelchair and sat on the floor for 5 seconds while the CNAs adjusted him in his wheelchair. Resident #15's catheter bag was picked up off the floor and hung on the wheelchair by CNA #2. After CNA #2 finished assisting Resident #15 she removed her gloves and washed her hands with soap and water.</p> <p>b. On 9/26/18 at 7:03 AM, Resident #23 was observed being assisted by CNA #1 and CNA #2.</p> <p>CNA #2 was observed applying lotion to Resident #23's legs and feet. Resident #23's feet did not have areas of skin impairment.</p> <p>CNA #1 emptied Resident #23's catheter bag into a container and took the container to the</p>	F 880			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135064</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/28/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COUNTRYSIDE CARE &amp; REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1224 EIGHTH STREET RUPERT, ID 83350</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 880	<p>Continued From page 62</p> <p>bathroom and emptied the contents into the toilet. CNA #1 did not remove her gloves or perform hand hygiene before returning to Resident #23's bedside. CNA #1 then assisted Resident #23 with placing stockings on her legs and applied braces on her legs. CNA #1 assisted Resident #23 with her hair without changing her gloves after she emptied Resident #23's catheter.</p> <p>After the braces were placed on Resident #23's legs CNA #2 assisted her with pericare. When the pericare was completed CNA #2 removed her gloves, applied hand sanitizer, rubbed her hands together for 2 seconds, wrung her hands in the air, and applied new gloves.</p> <p>On 9/26/18 at 8:24 AM, CNA #1 stated she changed gloves when her hands were soiled such as after pericare or if she were to empty a catheter. CNA #1 stated she forgot to change her gloves and sanitize her hands when she emptied Resident #23's catheter. CNA #1 did not know how long to use the hand sanitizer. She stated she applied it to her hands and rubbed for a few seconds. CNA #1 stated she forgot to rub her hands together until the hand sanitizer was dry.</p> <p>On 9/26/18 at 8:34 AM, CNA #2 stated she thought she was to use hand sanitizer for 10-15 seconds. CNA #2 stated it was difficult to place the gloves on and she should have washed her hands better.</p> <p>On 9/27/18 at 4:06 PM, the Infection Control Nurse stated staff should perform adequate hand hygiene between cares.</p>	F 880			
F 881 SS=D	Antibiotic Stewardship Program CFR(s): 483.80(a)(3)	F 881		11/16/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135064</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/28/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COUNTRYSIDE CARE &amp; REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1224 EIGHTH STREET RUPERT, ID 83350</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 881	<p>Continued From page 63</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)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and policy review, it was determined the facility failed to ensure the antibiotic stewardship program was implemented. This was true for 1 of 2 residents (Resident #6) reviewed for a UTI. This deficient practice created the potential for harm for Resident #6 to develop a resistance to antibiotics which could lead to super infection. Findings include:</p> <p>Resident #6 was readmitted to the facility on 12/5/17, with diagnoses which included Parkinson's, benign prostatic hyperplasia (enlarged prostate gland), UTI, and chronic kidney disease.</p> <p>A quarterly MDS assessment, dated 7/3/18, documented Resident #6 was cognitively intact and required extensive assistance of 1-2 staff members with care. The MDS documented he had a urinary catheter.</p> <p>The care plan area addressing Resident #6's UTI, initiated 9/18/18, documented Resident #6 was receiving antibiotics for a UTI. The care plan documented staff were to administer the</p>	F 881	<p>1. Resident #6 had one antibiotic discontinued on 9-27-18.</p> <p>2. The facility has determined that all residents have the potential to be affected.</p> <p>All residents' records will be reviewed for treatment with multiple unnecessary antibiotics</p> <p>3. An in-service education program will be conducted on November 6 and 8, 2018 by the DON and the Administrator with all nursing staff addressing the importance of using the appropriate amount and type of antibiotic.</p> <p>4. The DON, or designee, will conduct a random audit of up to five (5) residents with an infection weekly for four (4) consecutive weeks. The residents records will be reviewed and the results will be reviewed at the monthly Quality meeting.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135064</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/28/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COUNTRYSIDE CARE &amp; REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1224 EIGHTH STREET RUPERT, ID 83350</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 881	<p>Continued From page 64</p> <p>medications per physician orders and monitor for side effects of the medication.</p> <p>A Physician's Order, dated 9/18/18, documented staff were to change Resident #6's catheter, collect a UA, a C&amp;S (A culture is a test to find germs, such as bacteria or a fungus, that can cause infection. A sensitivity test checks to see what kind of medicine, such as an antibiotic, will work best to treat the illness or infection), and start Ciprofloxacin (antibiotic) 500 mg twice daily for 10 days.</p> <p>UA results from 9/19/18, documented Resident #6's urine contained blood, other proteins, and bacteria. Resident #6's C&amp;S result, dated 9/19/18, documented the presence of Proteus Mirabilis (organism which may cause infections). The results documented the Proteus Mirabilis was resistant to Ciprofloxacin. Resident #6's 9/19/18 through 9/27/18 MAR documented he was administered the Ciprofloxacin twice daily.</p> <p>A 9/21/18 Physician's order documented Resident #6 was to be started on 1 gm of intravenous Invanz (antibiotic) for 7 days. Resident #6's 9/22/18 through 9/27/18 MAR documented he was administered the Invanz daily.</p> <p>Resident #6 received both antibiotics from 9/22/18 to 9/27/18, for a total of 5 days.</p> <p>On 9/27/18 at 11:05 AM, the DON stated Resident #6 was started on Invanz for a UTI. The DON stated she was not aware he was on Ciprofloxacin as well for the UTI. The DON stated the Infection Control RN may have more</p>	F 881			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135064</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/28/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COUNTRYSIDE CARE &amp; REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1224 EIGHTH STREET RUPERT, ID 83350</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 881	Continued From page 65 information.  On 9/27/18 at 3:03 PM, the Infection Control RN stated she was not aware Resident #6 was on both Invanz and Ciprofloxacin. The Infection Control RN stated she notified the physician as soon as the DON spoke with her.  On 9/27/18 at 3:45 PM, the DON stated the nursing staff should have called the physician as soon as they noticed both medications were still ordered for Resident #6's UTI.	F 881			

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001490</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/28/2018</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>COUNTRYSIDE CARE &amp; REHABILITATION</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1224 EIGHTH STREET RUPERT, ID 83350</b>
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

C 000	<p><b>INITIAL COMMENTS</b></p> <p>The following deficiencies were cited during the State licensure survey of your facility, conducted from September 24, 2018 to September 28, 2018.</p> <p>The surveyors conducting the survey were:</p> <p>Teresa Kobza, RDN, LD, Team Coordinator Wendi Gonzales, RN</p>	C 000		
C 492	<p>02.121,05,d,ix Meet Window Requirments</p> <p>ix. Each room shall have a window which can be opened without the use of tools. The window sill must not be higher than three (3) feet above the floor and shall be above grade. The window shall be at least one- eighth (1/8) of the floor area and shall be provided with shades or drapes; This Rule is not met as evidenced by: Based on observation, and resident and staff interview, it was determined the facility failed to ensure resident rooms on the West hall had windows which opened. This affected 4 of 12 (#4, #6, #21, and #83) sampled residents and all other residents who resided on the West hall. Findings include:  On 9/24/18 from 3:00 PM to 3:45 PM, during the screen of the residents in rooms 301 through 317, the windows were observed and could not be opened. Several residents who resided in these rooms said there were no concerns regarding their windows.  On 9/28/18 at 11:40 am, the Administrator said the windows in rooms 301 through 317 were</p>	C 492	Please continue the window waiver for rooms 301 through 317	10/31/18

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  Electronically Signed	TITLE	(X6) DATE  10/31/18
--	-------	---------------------------

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001490</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/28/2018</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>COUNTRYSIDE CARE &amp; REHABILITATION</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1224 EIGHTH STREET RUPERT, ID 83350</b>
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 492	Continued From page 1  non-operable and could not be opened. The Administrator said the facility would continue to request a waiver of this requirement.	C 492		