



IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

TAMARA PRISOCK—ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
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BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
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January 31, 2019

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

Provider #: 135064

Dear Ms. Sorensen:

On **January 11, 2019**, we conducted an on-site revisit to verify that your facility had achieved and maintained compliance. We presumed, based on your allegation of compliance, that your facility was in substantial compliance as of **November 16, 2018**. However, based on our on-site revisit we found that your facility is not in substantial compliance with the following participation requirements:

F0000 -- S/S: -- -- Initial Comments

F0686 -- S/S: D -- 483.25(b)(1)(i)(ii) -- Treatment/svcs To Prevent/heal Pressure Ulcer

F0803 -- S/S: D -- 483.60(c)(1)-(7) -- Menu Meet Resident Nds/prep In Adv/followed

F0655 -- S/S: D -- 483.21(a)(1)-(3) -- Baseline Care Plan

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.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **February 10, 2019**. The components of a Plan of Correction, as required by CMS must:

- Address what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- Address how you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- Address what measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;
- Indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained.
- Include dates when corrective action will be completed in column (X5).

If the facility has not been given an opportunity to correct, the facility must determine the date compliance will be achieved. If CMS has issued a letter giving notice of intent to implement a denial of payment for new Medicare/Medicaid admissions, consider the effective date of the remedy when determining your target date for achieving compliance.

- The administrator must sign and date the first page of the federal survey report, Form CMS-2567 and the state licensure survey report, State Form (if applicable).

All references to federal regulatory requirements contained in this letter are found in *Title 42, Code of Federal Regulations*.

As noted in the Bureau of Facility Standards' letter of **October 22, 2018**, following the survey of **September 28, 2018**, we have already made the recommendation to the Centers for Medicare and Medicaid Services (CMS) for a civil monetary penalty, Denial of Payment for New Admissions and termination of the provider agreement on **March 28, 2019**, if substantial compliance is not achieved by that time. The findings of non-compliance on **January 11, 2019**, has resulted in a continuance of the remedy(ies) previously mentioned to you by the CMS. On , CMS notified the facility of the intent to impose the following remedies:

- DPNA made on or after **December 28, 2018**
- Civil money penalty,

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

Bonnie Sorensen, Administrator

January 31, 2019

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If you believe the deficiencies have been corrected, you may contact Debby Ransom, RN, RHIT, Bureau Chief, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 5; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance.

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

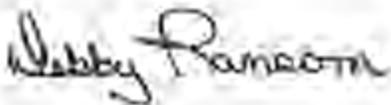
[2001-10 Long Term Care Informal Dispute Resolution Process](#)

[2001-10 IDR Request Form](#)

This request must be received by **February 10, 2019**. If your request for informal dispute resolution is received after **February 10, 2019**, 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 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

Enclosures

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

PRINTED: 02/06/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135064	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 01/11/2019
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE CARE & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 1224 EIGHTH STREET RUPERT, ID 83350		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{F 000}	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the revisit survey conducted January 10, 2019 -January 11, 2019.</p> <p>The surveyors conducting the survey were:</p> <p>Linda Kelly, RN, Team Coordinator Wendi Gonzales, RN</p> <p>Abbreviations:</p> <p>CNA = Certified Nursing Assistant DON = Director of Nursing RN = Registered Nurse</p> <p>F 655 Baseline Care Plan SS=D CFR(s): 483.21(a)(1)-(3)</p> <p>§483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must-</p> <p>(i) Be developed within 48 hours of a resident's admission.</p> <p>(ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-</p> <p>(A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable.</p>	{F 000}			

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

TITLE

(X6) DATE

Electronically Signed

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

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F 655	Continued From page 1 §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility failed to ensure baseline care plans were in place within 48 hours of admission. This was true for 1 of 2 residents (#135) whose baseline care plans were reviewed. The failure created the potential for harm when the resident or his representative were not included in planning his care. Findings include: Resident #135 was admitted to the facility on 1/7/19 with multiple diagnoses including a left tibial (shinbone) fracture.	F 655			

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F 655	Continued From page 2 On 1/11/19 at 12:30 PM, LPN #1 directed the surveyor to a binder at the nurses' station, which he said contained residents' baseline care plans. Resident #135's baseline care plan was blank, except for his name, admission date, and code status. LPN #1 reviewed the baseline care plan with Resident #135's name on it and said it was essentially blank. The DON arrived at 12:45 PM and joined the conversation. She reviewed the baseline care plan with Resident #135's name on it and said it should have been filled out but it was not.	F 655			
{F 686} SS=D	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 observation, family and staff interview, and record review, it was determined the facility failed to ensure a pressure ulcer was identified, assessed, monitored, and treatment provided in a timely manner for 1 of 3 residents (#135) reviewed for pressure ulcers. The failure created the potential for harm if Resident #135's Stage II	{F 686}			

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{F 686}	<p>Continued From page 3</p> <p>right ankle pressure ulcer worsened. Findings include:</p> <p>Resident #135 was admitted to the facility on 1/7/19, with multiple diagnoses including a left tibial (shinbone) fracture.</p> <p>On 1/10/19 at 10:30 AM, Resident #135 was observed asleep in his bed and his daughter was in the room. Resident #135's daughter said Resident #135 had a sore on his right inner (medial) ankle bone. She said the sore developed in the hospital because his right ankle rubbed up against his left leg cast. She said she had asked facility staff to put a sock on his right foot, and they did. Resident #135's daughter lifted the covers off his feet and lower legs. A hard cast was on his left leg, from the upper thigh to just below his toes, and a sock was on his right foot. Resident #135's daughter removed the sock and showed the surveyor a dry scabbed area, approximately 1/2 centimeter (cm) in diameter, on his right medial ankle. Resident #135's daughter said the sore looked better.</p> <p>Resident #135's baseline care plan was blank, except for his name, admission date, and code status.</p> <p>A second care plan documented 3 problems, including the risk for an alteration in Resident #135's skin integrity related to fragile skin on his coccyx on admission, decreased mobility, and a hard cast on his left leg. The goals for this problem were for his skin to remain intact and free from breakdown. Interventions included skin checks per facility protocol and to monitor his skin for signs/symptoms of breakdown, and to</p>	{F 686}			

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{F 686}	<p>Continued From page 4</p> <p>report concerns to a nurse. The problem, goals, and interventions did not include an initiation date. The second care plan did not document other skin problems and did not mention the sore on Resident #135's right ankle.</p> <p>Resident #135's Initial Nursing Assessment, dated 1/7/19, documented his general skin condition was moist and warm. A box to mark a history of pressure ulcers in the last 90 days was blank.</p> <p>Resident #135's 1/7/19 Skin Risk assessment, related to the use of a device, documented the presence of a left leg cast. Other skin integrity concerns were not mentioned on the assessment.</p> <p>Resident #135's Weekly Skin Checks documented the following:</p> <p>* 1/7/19 - Fair turgor, fragile skin at the coccyx area, a left hand bruise, the hard cast on his left leg, and to see nurses' notes were documented. A box to check to initiate the pressure area protocol was blank, and a box for "No Skin Issues" was marked. Resident #135's right right ankle sore was not mentioned.</p> <p>* 1/10/19 - Fair turgor, fragile skin at the coccyx area, and the left hand bruise was documented. Resident #135's left leg cast and right ankle sore were not mentioned.</p> <p>Nursing Notes for 1/7/19 through 1/10/19 at 10:58 AM, did not contain documentation about the sore on Resident #135's right ankle. The 10:58 AM entry on 1/10/19, documented no new</p>	{F 686}			

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{F 686}	<p>Continued From page 5 skin issues were noted since his admission.</p> <p>On 1/10/19 at 4:00 PM, RN #1, the facility's wound nurse, was asked about the sore on Resident #135's right medial ankle. RN #1 said she was not aware of a right ankle sore. She said she would assess it right away.</p> <p>A Nursing Note, dated 1/10/19 at 4:17 PM, documented RN #1 talked with Resident #135's daughter who confirmed the right medial ankle sore happened at the hospital from Resident #135 rubbing his right ankle on the left leg cast. RN #1 documented the right medial ankle area was dry and lightly scabbed, pinkish red in color, and measured 0.4 cm x [by] 0.5 cm x 0.0 cm. RN #1 also documented the right ankle sore/wound was reassessed with the DON present and the physician would be contacted to request an order for an Optifoam dressing to protect the wound.</p> <p>A subsequent Nursing Note, dated 1/10/19 at 5:09 PM, documented RN #1 staged the right medial ankle sore as a Stage II pressure ulcer (partial thickness skin loss). It documented RN #1 cut a tube sock to fit the ankle area of the cast. The Nursing Note also documented RN #1 visited with Resident #135 about wearing a sock on the right foot and not rubbing his foot on the cast, as doing so could cause a larger wound.</p> <p>On 1/11/19 at 11:00 AM, RN #1 said the right medial ankle Stage II pressure ulcer was not documented on Weekly Skin Checks on 1/7/19 or 1/10/19. She stated the skin checks were not thorough because the right medial ankle pressure ulcer was "prominent and easy to find." She added that none of the CNAs had reported</p>	{F 686}			

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{F 686}	Continued From page 6 skin concerns to a nurse.	{F 686}			
{F 803} SS=D	<p>Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7)</p> <p>§483.60(c) Menus and nutritional adequacy. Menus must-</p> <p>§483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.;</p> <p>§483.60(c)(2) Be prepared in advance;</p> <p>§483.60(c)(3) Be followed;</p> <p>§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;</p> <p>§483.60(c)(5) Be updated periodically;</p> <p>§483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and</p> <p>§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 by: Based on review of menus and Resident Council minutes, and resident, family, and staff interviews, it was determined the facility failed to ensure menus were updated to reflect residents' dietary choices. This was true for 3 of 21 residents (#11, #135, and #137) who consumed</p>	{F 803}			

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{F 803}	<p>Continued From page 7</p> <p>food prepared in the facility. The failure created the potential for harm if residents experienced weight loss related to dissatisfaction with their meals or meal times. Findings include:</p> <p>The facility was cited at F803 at the time of the 9/28/18 recertification survey. The facility's Plan of Correction documented new menus would be implemented effective 11/16/18.</p> <p>On 1/10/19 at 9:40 AM, during a brief tour of the kitchen, the Kitchen Supervisor/Office Aide (KS/OA) said new menus would be ready in two weeks. The Food Service Director (FSD) was present at the time and said it was his first day on the job.</p> <p>1. On 1/10/19 at 10:30 AM, Resident #135 was observed asleep in his bed. His daughter was present and said he was admitted to the facility 3 days prior. She also said he had not been offered a choice of what to eat or when to eat. She stated, "They just bring it."</p> <p>On 1/10/19 at 12:42 PM, Resident #135 was observed awake in bed. He said he had already eaten lunch and he did not like it. He said, "Its different food than I ever ate before." He said he did not get a choice of what to eat and he would like to be able to choose the food he wanted to eat.</p> <p>2. On 1/10/19 at 10:45 AM, Resident #137 was observed awake in bed. She said she was admitted to the facility about a week ago prior. She said she did not get to choose what to eat and that she did not like scrambled eggs. She said she knew her diet was restricted but it</p>	{F 803}			

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{F 803}	<p>Continued From page 8</p> <p>"upset" her to not be able to choose.</p> <p>3. On 1/10/19 at 10:46 AM, Resident #11 stated the facility served too much chicken and turkey.</p> <p>On 1/10/19 at 1:08 PM, the Supervisor/Certified Dietary Manager (S/CDM) assisted the FSD to locate and provide a copy of the current menus.</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; and, it lacked vegetarian options on the alternative menus.</p> <p>On 1/10/19 at 5:10 PM, the S/CDM said the facility's menus had not been changed because the facility was waiting for the corporate Registered Dietitian (RD) to approve and sign off on the menus. She said there had been no change regarding how often chicken or turkey was on the menu and that vegetarian food choices were not on the menu. The S/CDM said, however, that vegetarian options, independent of the menus, were being offered to one resident who wanted vegetarian food.</p> <p>On 1/10/19 at 6:00 PM, the facility RD arrived at the steam table in the main dining room where the S/CDM was plating food for the evening meal service. The RD said the first two weeks of the new menus had been approved and were ready to be implemented. The RD also said that she would review the remaining part of the new menus as soon as possible.</p> <p>Resident Council meeting minutes, dated 12/20/18, documented the staff were to check on</p>	{F 803}			

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{F 803}	Continued From page 9 when the new menus would be initiated. On 1/11/19 at 12:15 PM, the Licensed Social Worker (LSW) said she was present during the Resident Council meeting on 12/20/18 and the residents wanted to know when the new menus would be in effect. The LSW said she talked to either the S/CDM or the previous FSD several days later and was told they were working on it.	{F 803}			

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001490	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 01/11/2019
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NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE CARE & REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 1224 EIGHTH STREET RUPERT, ID 83350
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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{C 000}	INITIAL COMMENTS	{C 000}		
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Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE
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