



IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
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February 7, 2020

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

Provider #: 135064

Dear Ms. Sorensen:

On **January 24, 2020**, a survey was conducted at Countryside Care & Rehabilitation by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567 listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed.

NOTE: The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct." **Please provide ONLY ONE completion date for each federal and state tag (if applicable) in column (X5) Completion Date** to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.

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 **February 18, 2020**. Failure to submit an acceptable PoC by **February 18, 2020**, may result in the imposition of penalties by **March 11, 2020**.

The components of a Plan of Correction as required by CMS must:

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

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

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

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

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **February 28, 2020 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **April 24, 2020**. A change in the seriousness of the deficiencies on **March 9, 2020**, may result in a change in the remedy.

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The remedy, which will be recommended if substantial compliance has not been achieved by **April 24, 2020** includes the following:

Denial of payment for new admissions effective **April 24, 2020**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying non-compliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **July 24, 2020**, if substantial compliance is not achieved by that time.

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

If you believe these deficiencies have been corrected, you may contact Belinda Day, RN or Laura Thompson, RN, Supervisors Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 2; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **April 24, 2020** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

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

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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 18, 2020**. If your request for informal dispute resolution is received after **February 18, 2020**, 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 Belinda Day, RN, or Laura Thompson, RN, Supervisors, Long Term Care Program at (208)334-6626, option #2.

Sincerely,



Belinda Day, RN, Supervisor
Long Term Care Program

bd/dr

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

PRINTED: 02/24/2020
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 01/24/2020
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	INITIAL COMMENTS The following deficiencies were cited during the federal recertification and complaint survey conducted from January 21, 2020 to January 24, 2020. The surveyors conducting the survey were: Presie C. Billington, RN, Team Coordinator Brad Perry, LSW Kim Saccomando, RN Abbreviations: CNA = Certified Nursing Assistant DON = Director of Nursing LPN = Licensed Practical Nurse MDS = Minimum Data Set POST = Physician Orders for Scope of Treatment mg = milligrams ml = milliliter RN = Registered Nurse RNA = Restorative Nurse Assistant	F 000			
F 578 SS=E	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the	F 578		2/28/20	

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

TITLE

(X6) DATE

Electronically Signed

02/17/2020

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 578	<p>Continued From page 1</p> <p>requirements specified in 42 CFR part 489, subpart I (Advance Directives).</p> <p>(i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.</p> <p>(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.</p> <p>(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law.</p> <p>(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, policy review, and staff interview, it was determined the facility failed to ensure resident records included an Advance Directive. This was true for 4 of 12 residents (#5, #9, #10, #25) whose records were reviewed for Advance Directives. This failed practice created the potential for harm if residents' wishes regarding end of life or emergent care were not honored if they became unable to make their</p>	F 578	<p>1. Those residents (5),(9),(10),(25), who were found to be affected by the deficient practice will have an advance directive placed into their chart or documentation explaining why one is not available.</p> <p>2. All residents have the potential to be affected by the same deficient practice. All resident charts will be audited to verify</p>		

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F 578	<p>Continued From page 2 wishes known. Findings include:</p> <p>The State Operations Manual, Appendix PP, defines an "Advance Directive" as "a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated." "Physician Orders for Life-Sustaining Treatment (or POLST) paradigm form" is a form designed to improve patient care by creating a portable medical order form that records patients' treatment wishes so that emergency personnel know what treatments the patient wants in the event of a medical emergency, taking the patient's current medical condition into consideration. A POLST paradigm form is not an advance directive."</p> <p>The facility's Advanced Directive policy approved on 3/15/19, documented the following:</p> <p>* Upon admission, the facility determined if the resident had an Advance Directive, POST form, or other instructions in case the resident became incapacitated.</p> <p>*The facility determined if the resident wanted to make an Advanced Directive if they did not have one.</p> <p>This policy was not followed.</p> <p>1. Resident records did not include documentation Advance Directives were discussed or offered, and did not have an Advance Directive in their record as follows:</p>	F 578	<p>if an advance directive is in the chart. If an advance directive is not in the chart then the residents representative will be notified. If one is available then it will be placed in the resident chart, if one is not available then documentation will be completed to explain why.</p> <p>3. The advance directive policy was reviewed and updated to state that each resident will have an advance directive in their chart or documentation as to the reason why. All new admission charts will be reviewed for an advance directive within one week of admission. Staff education will be done (nursing and admissions)to address the deficit practice.</p> <p>4. An audit of all new admission charts will be done weekly by the Social Service Director or her assigned representative to verify the presence of an advance directive until 100% compliance is attained. Then monthly until 100% compliance is attained and quarterly. The results of the audit will be reviewed by the quality committee and the administrator in the monthly Quality Meeting to verify compliance.</p>		

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F 578	Continued From page 3 a. Resident #9 was admitted to the facility on 8/9/19, with multiple diagnoses which included dementia, major depressive disorder, repeated falls, and chronic pain. Resident #9's physician orders, dated 8/12/19, documented her code status was DNR (Do Not Resuscitate). Resident #9's record documented she had a signed POST, initiated on 1/15/18. Resident #9's record did not include or have documentation an Advance Directive was discussed or offered. b. Resident #10 was admitted on 12/18/18, with multiple diagnoses including Alzheimer's disease, heart failure, depression, and anxiety. Resident #10's physician orders, dated 4/22/17, documented her code status was DNR. Resident #10's care plan documented she had a signed POST by her appointed health care representative and her physician. The POST in her record was dated 3/25/19. Resident #10's record did not include or have documentation about an Advance Directive. c. Resident #25 was admitted to the facility on 12/18/18, with multiple diagnoses including Type 2 diabetes mellitus, hypertension, skin cancer, and weakness. Resident #25's care plan documented she had a	F 578			

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F 578	<p>Continued From page 4</p> <p>signed POST by her appointed health care representative and her physician and a DPOA.</p> <p>On 1/22/20 at 11:52 AM, Resident #25's record did not include or have documentation about an Advance Directive.</p> <p>On 1/22/20 at 4:08 PM, the Social Services Director stated she thought the POST form was the Advance Directive for residents. She was unable to locate Advance Directives in the residents' records.</p> <p>2. Resident #5 was admitted to the facility on 12/7/18, with multiple diagnoses including dementia.</p> <p>Resident #5's quarterly MDS assessment, dated 10/29/19, documented he had severe cognitive impairment.</p> <p>Resident #5's care plan, dated 8/22/19, documented he had an Advance Directive and it was discussed with him and with his appointed health care representative.</p> <p>Resident #5's record included a Durable Power of Attorney related to managing his finances and property and a POST which documented his code status of DNR. Resident #5's record did not include a copy of a DPOA for healthcare.</p> <p>On 1/22/20 at 4:06 PM, the LSW said the Advance Directive was discussed with the residents and/or their representatives quarterly during their care conferences. The LSW reviewed the DPOA documents for Resident #5 and said they were for financial services. The</p>	F 578			

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F 578	Continued From page 5 LSW said Resident #5 had a POST and it was his Advance Directive. The LSW reviewed Resident #5's record and said she did not find an Advance Directive.	F 578			
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on policy review, record review, and	F 625		2/28/20	
			1. Resident (2) record was reviewed and		

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F 625	<p>Continued From page 6</p> <p>resident and staff interview, it was determined the facility failed to ensure a bed hold notice was provided to residents and their representatives upon transfer to the hospital. This was true for 1 of 1 resident (Resident #12) who was reviewed for transfer. This deficient practice created the potential for harm if residents and their representatives were not informed of the residents' rights to return to their former bed/room at the facility within a specified time. Findings include:</p> <p>The facility's Bed Hold policy, undated, documented the following:</p> <ul style="list-style-type: none"> * Upon admission to the facility a bed hold policy was provided to the resident or their representatives. * A second letter of the bed hold policy was provided to the residents or their representatives upon transfer to the hospital or alternative treatment center. * In case of an emergency transfer, a written notice was provided to residents or their representatives within 24 hours of transfer. <p>This policy was not followed.</p> <p>Resident #12 was admitted to the facility on 11/17/19, with multiple diagnoses including anxiety disorder.</p> <p>A discharge MDS assessment, dated 11/3/19, documented Resident #12 was discharged to a hospital.</p>	F 625	<p>no adverse affects were noted. She was admitted back into her same room following her discharge from acute care.</p> <p>2. All residents who were discharged from the facility to the hospital or on therapeutic leave have the potential to be affected by the same deficient practice. An audit of these residents will be completed to identify any who were affected</p> <p>3. The Bed Hold policy was reviewed and no changes were needed. A new Bed Hold letter will be created to give to the residents or their representative upon discharge to the hospital or therapeutic leave. Nursing staff were presented with training at the licensed staff meeting on 02-04-2020. Other staff education will be completed prior to and again at the March staff meeting.</p> <p>4. An audit of all hospital and therapeutic discharges will be done by the Director of Nursing or her appointed representative weekly until 100% compliance is obtained. Then audits will be done monthly until 100% for 3 months then quarterly. Audit results will be reported to the Quality Committee and the Administrator at the monthly Quality Meeting to verify compliance.</p>		

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F 625	Continued From page 7 A nurse's note, dated 11/3/19 at 10:25 AM, documented Resident #12's oxygen saturation was 84% on room air and she had shortness of breath, weakness, and decreased appetite. Resident #12 was sent to the emergency room per her representative's request. Resident #12's record did not include documentation a bed hold notice was provided to her and her representative when she was transferred to the hospital. On 1/22/20 at 4:21 PM, LPN #1 said Resident #12 was readmitted to the same room she was in before she was transferred to the hospital. LPN #1 said she thought the bed hold notice was provided by the Billing office to the resident or to their representative. On 1/22/20 at 4:36 PM, the DON said she was not aware if a bed hold notice was provided to Resident #12 and her representative.	F 625			
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, policy review and staff interview, it was determined the facility failed to	F 684	1. Resident (8) had a chart review and it was found that she was not affected by	2/28/20	

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F 684	<p>Continued From page 8</p> <p>ensure professional standards were met for bowel care. This was true for 1 of 4 residents (Resident #8) who were reviewed for bowel and bladder incontinence. This failed practice had the potential to place residents at risk for fecal impaction when orders were not followed regarding bowel management. Findings include:</p> <p>The facility's undated Bowel Habits policy documented the following:</p> <ul style="list-style-type: none"> * When a resident did not have a bowel movement in 24 hours, staff were directed to administer prune juice in the morning, and if no bowel movement, to give it again in the evening, assess the resident, and chart the results. * If the resident did not have a bowel movement on the third day, staff were directed to administer Milk of Magnesia (MOM) to the resident. * If the resident did not have a bowel movement on the fourth day, staff were directed to administer a suppository or enema to the resident. If no results at that time, staff were directed to assess the resident for general appearance, vomiting, vital signs, bowel sounds, abdominal assessment, and complaints or concerns, and refer to the physician. <p>This policy was not followed.</p> <p>Resident #8 was admitted to the facility on 12/18/18, with multiple diagnoses including traumatic brain injury.</p> <p>Resident #8's annual MDS assessment, dated 11/5/19, documented she was cognitively intact</p>	F 684	<p>the deficient practice.</p> <p>2. All residents who are at risk for constipation have the potential to be affected by the same deficient practice. An initial audit of current residents who have not had a bowel movement within 3 days will be completed to see if bowel protocols were followed.</p> <p>3. The policy for Bowel Habits was reviewed and it was found that no changes needed to be made. Staff education will be done so staff is aware of the signs and symptoms of constipation, who is at risk, the proper process for interventions and how to document the interventions. Education will be done prior to and again at the March staff meeting on 3-3-2020.</p> <p>4. An audit of those residents who meet the criteria for bowel interventions will be done by the Director of Nursing or her appointed representative weekly until 100% compliance is obtained. Then monthly until 100% for three months, then quarterly. Audit results will be reported to the Quality Committee and the Administrator at the monthly Quality Meeting to verify compliance.</p>		

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F 684	<p>Continued From page 9 and was incontinent of bowel and bladder.</p> <p>Resident #8's physician's order included the following:</p> <ul style="list-style-type: none"> * Polyethylene glycol (a laxative), 17 grams mixed in water or juice until completely dissolved every morning. * Sennosides-docusate sodium (a laxative/stool softener), two tablets every morning. * Bisacodyl suppository (a laxative), insert one suppository rectally if no bowel movement on the fourth day. <p>Resident #8's Bowel Movement Records, dated 12/1/19 through 1/23/20, documented she did not have a bowel movement from 12/24/19 through 12/29/19 (6 days), or from 12/31/19 through 1/3/20 (4 days).</p> <p>There was no documentation Resident #8 was offered or received MOM as directed by the facility's Bowel Habits policy, or the Bisacodyl suppository, as directed by her physician's order. Additional bowel care interventions were not documented.</p> <p>On 1/23/20 at 3:42 PM, the DON said if a resident did not have a bowel movement in 24 hours, prune juice was administered and it was administered again if they did not have a bowel movement on the second day. The DON said prune juice administration was not recorded in residents' record because it was not a medication. The DON then reviewed Resident #8's records and said she did not see that MOM was administered to Resident #8. The DON said Resident #8 could have received MOM or a</p>	F 684			

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F 684	Continued From page 10	F 684			
F 732 SS=C	<p>suppository, but the nurse forgot to document it.</p> <p>Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4)</p> <p>§483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis:</p> <ul style="list-style-type: none"> (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: <ul style="list-style-type: none"> (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. <p>§483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors.</p> <p>§483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>§483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of</p>	F 732		2/28/20	

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F 732	<p>Continued From page 11</p> <p>18 months, or as required by State law, whichever is greater.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, policy review and staff interview, it was determined the facility failed to ensure the nurse staffing information was posted daily per shift in a clear and easy to understand format. This failed practice had the potential to affect all residents in the facility and their representatives, visitors, and others who wanted to know the facility's staffing levels. Findings include:</p> <p>The facility's Staffing information policy, undated, documented the facility posted the nurse staffing information daily in a clear and readable format in a prominent place readily accessible to residents and visitors with the following information: Facility name, current date, the total number of RNs, LPNs and CNAs and the actual hours they worked.</p> <p>This policy was not followed.</p> <p>On 1/21/20 at 3:31 PM, the facility's Nurse Staffing Data Sheet was observed posted on the bulletin board in front of the East Wing Nurses' Station. The posted information was for the day, evening and night shift, and documented the following:</p> <p>* Day Shift: RNs - 0 (zero), LPNs - 1.75, Aides - 6, RNAs - 1 * Evening Shift: RNs -1.75, LPNs - 1, Aides - 5.75, RNAs - 0.5 * Night Shift: RN's 1, LPNs - 0.25, Aides - 3, RNAs - 0</p>	F 732	<ol style="list-style-type: none"> 1. Upon record review no residents were found to be affected by the deficient practice. 2. All residents may have the potential to be affected by the same deficient practice. 3. The Nursing Services Staffing policy was reviewed and no changes were needed. A new form was created to help present nurse staffing information in a clear and understandable format. Staff training was done by the Director of Nursing and the Administrator on the correct way to complete the new form to present the information appropriately. 4. An audit of the posting of the nursing staff hours will be done weekly by the Director of Nursing or her appointed representative until 100% compliance is attained. Then monthly until 100% for three months, then quarterly. Audit results will be reported to the Quality Committee and the Administrator at the monthly Quality Meeting to verify compliance. 		

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F 732	<p>Continued From page 12</p> <p>* The facility's census was 39 residents</p> <p>On 1/21/20 at 3:54 PM, the same Nurse Staffing Data Sheet information was observed posted on the bulletin board in the West Wing dining room.</p> <p>On 1/22/20 at 8:43 AM, the Nurse Staffing Data Sheet information was observed posted on the bulletin board in front of the East Wing Nurses' Station, and it was observed on the bulletin board of the West Wing Dining Room at 1/22/20 at 8:47 AM. The posted information documented the following:</p> <p>* Day Shift: RNs - 0, LPNs - 2.75, Aides - 6, RNAs - 1 * Evening Shift: RNs - 1, LPNs - 2, Aides - 6, RNAs - 0.5 * Night Shift: RNs - 1, LPNs 0.25, Aides - 3, RNAs - 0 * Facility's census - 41 residents</p> <p>The Nurse Staffing Data Sheets did not identify the numbers of actual hours worked or if it was the number of staff working.</p> <p>On 1/22/20 at 2:05 PM, the Administrator was interviewed and the DON was present on the phone. The Administrator said the DON prepared the schedule, and the night shift nurse completed the nurse staffing data information and posted it on the East and West Wing bulletin boards. The Administrator said the number 1.75 for RNs on the 1/21/20 Nurses Staffing Data Sheet meant 1 RN worked for 8 hours and another RN worked for 3/4 of an 8-hour shift. The Administrator said the number 5.75 for Aides meant 5 CNAs worked for 8 hours and one CNA worked for 3/4 of an</p>	F 732			

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F 732	Continued From page 13 8-hour shift. When asked about the information regarding the total number of hours and actual hours worked by each staff, the Administrator did not give an answer.	F 732			
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §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 Based on a comprehensive assessment of a resident, the facility must ensure that--- §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; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §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	F 758		2/28/20	

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F 758	<p>Continued From page 14</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 interview, record review, and policy review, it was determined the facility failed to ensure as needed psychotropic medications had a physician evaluation or documented rationale when the medication order extended beyond 14 days, and documentation of consent from the resident before administering the psychotropic medications. This was true for 4 of 6 residents (#3, #10, #12, and #139) who were reviewed for unnecessary medications. This deficient practice created the potential for harm if residents experienced adverse effects from unnecessary psychotropic medications. Findings include: The facility's Psychotropic Drug Committee policy, undated, stated each resident's drug regimen was reviewed periodically to monitor for effectiveness, appropriateness and the need for reduction.</p>	F 758	<p>1. Resident (3) who is taking lorazepam 0.5 mg - 1 mg q 6 hours prn had an update from the psychotropic drug committee sent to the physician for a rationale for the prn medication. Resident (10) who is taking alprazolam 0.5 mg q day prn had an update from the psychotropic drug committee sent to the physician for a rationale for the prn medication. Resident (12) who is taking alprazolam 0.25 mg q 6 hours prn had an update from the psychotropic drug committee sent to the physician for a rationale for the prn medication. Resident (139) who is taking donepezil 5 mg 2 tabs qhs had a consent completed and presented to his family member for a signature.</p> <p>2. All residents who have a prn order for a</p>		

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F 758	<p>Continued From page 15 This policy was not followed.</p> <p>1. The following residents did not have a 14-day review of their as needed psychotropic medication.</p> <p>a. Resident #3 was admitted on 12/17/18, with diagnoses which included intrahepatic bile duct carcinoma (a type of liver cancer), dementia, heart failure, anxiety, and depression.</p> <p>Resident #3 had a physician order for Lorazepam (a psychotropic drug used to treat anxiety), 0.5-1.0 mg tablet every six hours every day as needed with a start date of 1/20/20, and an end date of 10/15/22.</p> <p>There was no recommendation for reevaluation of the necessity for the medication after the 14-day use in Resident #3's record, or a physician's documented rationale when the medication order extended beyond 14 days.</p> <p>b. Resident #10 was admitted on 12/18/18, with diagnoses which included Alzheimer's disease, heart failure, depression, and anxiety.</p> <p>Resident #10 had a physician order for Alprazolam (a psychotropic drug used to treat anxiety), 0.5 mg tablet to be given every day as needed with a start date of 11/6/19, and an end date of 8/1/22.</p> <p>There was no recommendation for reevaluation of the necessity for the medication after the 14-day use in Resident #10's record, or a physician;s documented rationale when the medication order extended beyond 14 days.</p>	F 758	<p>psychotropic drug are at risk to be affected by the same deficient practice. An audit of these residents record will be completed to determine who might be affected.</p> <p>All residents who have a diagnosis of dementia and receive medications used to treat confusion r/t dementia are at risk of being affected. An audit of these residents record will be completed to determine who might be affected.</p> <p>3. The psychotropic drug policy was reviewed and updated to reflect the 14 day policy and the consents needed for the dementia medications. Residents who are on medications to treat confusion r/t dementia will be added to the psychotropic drug committee quarterly review to verify consents have been obtained.</p> <p>4. A weekly audit of residents who have been placed on prn psychoactive medications will be completed by a member of the psychotropic drug committee until 100% compliance is met. Then monthly until 100% compliance for three months, then quarterly. A weekly audit of residents who have been placed on medications to treat confusion r/t dementia will be completed by a member of the psychotropic drug committee until 100% compliance is met. Then monthly until 100% compliance for three months then quarterly. All audit results will be reported to the</p>		

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F 758	<p>Continued From page 16</p> <p>On 1/24/20 at 9:40 AM, the DON stated she did not know about 14-day reviews for as needed psychotropic medication and the pharmacist had that information.</p> <p>On 1/24/20 at 9:47 AM, the Director of Pharmacy was interviewed concerning 14-day reevaluation of psychotropic medication for as needed use. The Director of Pharmacy stated he was aware of the 14-day regulation, but the facility policy did not address it and the facility was not reviewing as needed use of psychotropic medications.</p> <p>c. Resident #12 was admitted to the facility on 11/17/19, with multiple diagnoses including anxiety disorder.</p> <p>Resident #12's significant change MDS assessment, dated 11/13/19, documented she was cognitively intact and received antianxiety medication three of the past seven days.</p> <p>Resident #12's physician's orders included Alprazolam (anti-anxiety medication) 0.25 mg every six hours as needed with a start date of 11/7/19 and stop date of 8/2/22.</p> <p>There was no documentation in Resident #12's record to support the continuation of Alprazolam beyond 14 days.</p> <p>On 1/24/20 at 9:41 AM, the DON said Resident #12 did not want her anti-anxiety medication to be stopped. The DON also said she was not aware the as needed psychotropic medications needed to be reviewed after 14 days.</p>	F 758	<p>Quality Committee and the Nursing Home Administrator at the monthly Quality Committee meeting to verify compliance.</p>		

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F 758	Continued From page 17 On 1/24/20 at 9:46 AM, the Pharmacy Director said he was aware as needed psychotropic medications were to be reviewed after 14 days. The Pharmacy Director then reviewed Resident #12's physician's order and said her anti-anxiety order should have been discontinued after 14 days and a new order obtained from the physician. On 1/24/20 at 10:00 AM, the Pharmacy Director called the pharmacist who reviewed Resident #12's medication. The pharmacist said over the phone he was not aware as needed psychotropic medications needed to be reviewed by the physician after 14 days. 2. Resident #139 was admitted to the facility on 1/17/20, with multiple diagnoses which included dementia. Resident #139's January 2020 physician's orders documented he was to receive Donepezil (used to treat confusion related to dementia) 5 mg, two tablets at bedtime. There was no documentation in Resident #139's record he consented to use the Donepezil. There was no documentation regarding the beneficial effects and possible side effects of the medication. On 1/24/20 at 9:45 AM, the DON said the facility did not know they needed to get a consent for Donepezil since they did not consider it a psychotropic medication. The DON said Resident #139 did not have a consent for Donepezil.	F 758			
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)	F 761			2/28/20

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F 761	<p>Continued From page 18</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 observation, policy review, and staff interview, it was determined the facility failed to securely store controlled medications. This was true for 1 of 2 medication rooms, observed during the inspection of the medication storage areas. This failed practice created the potential for harm if the controlled medication was diverted or contaminated. Findings include: The facility's Controlled Drug Management policy, undated, did not address the need for</p>	F 761	<p>1. Upon review no residents were found to be affected by the deficient practice.</p> <p>2. All residents who live on West Wing have the potential to be affected by the deficient practice.</p> <p>3. The Policy for stored drugs was reviewed and updated to address the double locking of controlled medications. A locked box will be affixed to the wall</p>		

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F 761	<p>Continued From page 19</p> <p>separately locked, permanently affixed compartments for storage of Schedule II, III, IV, and V medications (Schedule II-V medications are medications that have an accepted medical use and have a potential for abuse, ranging from low to high, and may also lead to physical or psychological dependence).</p> <p>On 1/22/20 at 2:05 PM, an inspection of the locked medication storage room was completed with LPN #1 present. The medication storage room had an unlocked refrigerator for the storage of temperature-controlled medications. Among the medications in the refrigerator was a 30 ml bottle of Lorazepam solution, 2 mg/ml, and a 30 ml bottle of liquid Morphine Sulfate solution, 2mg/ml. Lorazepam is classified as a benzodiazepine medication, which is a Schedule IV medication (Schedule IV medications are classified as drugs with a low potential for abuse and low risk for dependence). Morphine Sulfate is classified as an opiate medication, which is a Schedule II use medication (Schedule II medications are classified as drugs with a high potential for abuse, with use potentially leading to severe psychological or physical dependence). When asked about a lock being on the refrigerator, RN #1 stated the facility has never had one, and they thought the single lock on the medication room door was sufficient.</p> <p>On 1/23/20 at 3:59 PM, RN #2 stated narcotics in the refrigerator needed to be locked separately. RN #2 stated "a few years ago" the facility had medication carts and the liquid narcotics were locked in a separate compartment of the medication cart. When the facility switched to the Pyxis system (the Pyxis system is a secured</p>	F 761	<p>inside of the locked medication room and inside of the refrigerator where only controlled substances will be stored. The floor nurse for each hall will have the accessible key for the locked med room and locked box. Nursing staff will be educated about the need for the controlled drugs to be separately locked in a permanently affixed storage compartment within the locked medication room away from other substances within the medication closet. Education will be done by the DON.</p> <p>4. A QA will be done weekly to determine compliance with the double locking of controlled substances until 100% for 4 weeks. Then monthly until 100% for three months then quarterly. The audit results will be reported to the Quality Committee and the Nursing Home Administrator at the monthly Quality Committee meeting to verify compliance.</p>		

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

PRINTED: 02/24/2020
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 01/24/2020
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE CARE & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 1224 EIGHTH STREET RUPERT, ID 83350		
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F 761	Continued From page 20 automated dispensing cabinet for medication) the liquid medications were moved to the unlocked refrigerator. On 1/24/20 at 10:49 AM, the DON was asked where narcotics were kept at the Nurses' station. She replied all narcotics were kept in the Pyxis. When notified there were narcotics in the unlocked refrigerator in one medication room, she replied they were liquids. When asked about a separate, locked, permanently affixed compartment for narcotics, she stated she was not aware of the double lock system, and the facility did not have one.	F 761			
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. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (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. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §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	F 812		2/28/20	

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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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F 812	<p>Continued From page 21</p> <p>by: Based on policy review, observation, and staff interview, it was determined the facility failed to ensure measures were in place to prevent possible cross-contamination of dirty to clean areas in the kitchen. This had the potential to affect the 39 residents residing in the facility who consumed food prepared by the facility. This failure created the potential for contamination if residents contracted food-borne illnesses. Findings include:</p> <p>The facility's Employee Sanitary Practices policy, dated 4/2010, directed staff to change aprons and wash hands when moving from the dirty to clean dish area; and to wear a clean apron when handling clean dishware.</p> <p>This policy was not followed.</p> <p>On 1/23/20 at 9:45 AM, Dishwasher Aide (DA) #1 and DA #2 were in the East dining room scraping off residents' dirty plates into the trash and stacked the plates in a dirty dish container. Both aides had on Polo type shirts that were not covered by aprons.</p> <p>On 1/23/20 at 10:07 AM, DA #1 was observed spraying the dirty dishes with water and then loading the dishes on a rack in the dishwasher. She had on a visibly food soiled apron and gloves. She then removed her gloves and washed her hands. She did not remove the soiled apron. DA #1 then put away the clean items which included a cutting board and meal trays while wearing the soiled apron.</p> <p>On 1/23/20 at 10:15 AM, DA #2 was observed</p>	F 812	<p>1. Upon review no residents were found to have been affected by the deficient practice.</p> <p>2. Inadequate sanitation practices could have the ability to affect 100% of the residents in the facility by having the potential to contract a food borne illness.</p> <p>3. This deficiency will be corrected by educating the staff and providing a minimum of monthly in-services regarding the deficiency practices by Food Service Director and quarterly by the facility Dietitian, In-services will include the following information: *Cross contamination of foods *Safe handling of food contact surfaces *Proper hand hygiene practices *Proper procedures to follow while handling dirty dishware *Proper procedures to follow while handling clean dishware</p> <p>4. An audit of proper dish room procedures will be done weekly by the Food Service Director to ensure proper handling of clean and dirty dishware until 100% compliance is met. Then monthly until 100% compliance for three months, then quarterly. All food and nutrition staff will be required to complete the Idaho Food Safety Exam.</p> <p>In-service notes and audit reports will be reviewed by the Quality Committee and</p>		

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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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F 812	<p>Continued From page 22</p> <p>putting away clean dishes. She had on the same Polo type shirt as observed in the dining room and did not wear an apron.</p> <p>On 1/23/20 at 10:21 AM, DA #1 said she did not change her apron prior to putting away the clean items. She said she did not know she had to change her apron before putting away clean items.</p> <p>On 1/23/20 at 10:23 AM, DA #2 said she never wore an apron when she put away clean dishes.</p> <p>On 1/23/20 at 10:26 AM, the Certified Dietary Manager (CDM) said she expected staff to remove their dirty aprons prior to putting away the clean dishes. She said staff did not normally wear aprons when putting away clean dishes.</p>	F 812	<p>the Nursing Home Administrator at the monthly Quality Meeting to verify compliance.</p>		

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 01/24/2020
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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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C 000	INITIAL COMMENTS The following deficiency was cited during the State Licensure survey at Countryside Care and Rehabilitation, conducted on January 21, 2020 to January 24, 2020. The surveyors conducting the survey were: Presie C. Billington, RN, Team Coordinator Brad Perry, LSW Kim Saccomando, RN	C 000		
C 492	02.121,05,d,ix Meet Window Requirments 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 3 of 12 (#31, #22, #35) residents and all other residents who resided on the West hall. On 1/23/20 beginning at 8:45- 9:10 AM, during the tour of rooms 301-317, the windows were observed and could not be opened. Several residents who resided in these rooms stated they had no concerns regarding their windows not opening. On 1/23/20 at 9:15 AM, the Administrator said the windows in rooms 301-317 were unable to be	C 492	1. No residents were found to be adversely affected by the inability to open the windows on West Wing. 2. All residents on West Wing have the potential to be affected. 3. A window waiver will continue to be requested for all windows on West Wing.	2/28/20

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

TITLE

(X6) DATE
02/17/20

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 01/24/2020
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C 492	Continued From page 1 opened and the facility would continue to request a waiver for this requirement.	C 492		



IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
DEBBY RANSOM, R.N., R.H.I.T – Chief
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March 25, 2020

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

Provider #: 135064

Dear Ms. Sorensen:

On **January 21, 2020** through **January 24, 2020**, an unannounced on-site complaint survey was conducted at Countryside Care & Rehabilitation. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00008113

Allegation #1: Residents are subjected to abuse and punishment.

Findings #1: The Licensed Social Worker (LSW) was interviewed on 1/24/20 at 10:55 AM. The LSW said she provided abuse training to staff upon hire, then once a year and when necessary. The LSW said any abuse or mistreatment of residents would not be tolerated.

The interactions between the staff and residents were observed throughout the survey. Staff interacted with the residents appropriately and answered call lights in a timely manner.

One Licensed Nurse (LPN) and 2 Certified Nursing Assistants (CNAs) were interviewed. The staff stated they received training in abuse. The LPN and the 2 CNAs said any mistreatment of residents by staff were reported to their supervisors. The LPN and the 2 CNAs said they had not observed any residents being mistreated by the staff.

Ten residents attended a group interview on 1/22/20 at 3:04 PM. No concerns were voiced regarding staff mistreating residents. One resident said she felt she was being ignored by the staff, but after an interview with the resident it was found out the resident liked the said staff member to leave her alone. The resident denied any mistreatment or verbal or physical abuse from the staff. The residents stated they knew how to file a grievance and the facility responded to their grievances in a timely manner. The residents stated they did not feel the staff retaliated against them when they filed their grievances.

The facility's Grievance file and Resident Council minutes from November 2018 to January 2020 were reviewed. There were no concerns documented in the Grievance file or in the Resident Council minutes related to residents being mistreated, bullied or punished by the staff, such as staff withholding residents' oxygen, staff taking residents' walkers, or staff not providing assistance to the residents.

Fifteen residents' records, including 12 active records (records of residents who were currently residing at the facility) and three closed records (records of residents who had been discharged from the facility) were reviewed. One closed record documented the resident required oxygen at 2 liters per minute continuously and he required assistance of one staff to complete activities of daily living. The resident was advised to press his call light when he needed assistance. The resident's record documented he was observed taking his oxygen off as he self-transferred from his bed to go to the bathroom. The resident also used his front wheel walker to self-transfer from the toilet to his recliner. The resident's care plan directed the staff not to leave his front wheel walker within his reach to encourage him to use his call light for assistance.

Seven residents were interviewed individually between 1/21/20 and 1/22/20, and none voiced concerns regarding the treatment they received from the staff. The residents stated the staff helped them with their activities of daily living as needed. The residents stated they had not observed any residents being mistreated by staff or staff ignoring residents. Six residents who used oxygen continuously were interviewed and said they had no concern with their oxygen use. The residents said they have their oxygen at all times.

Three family representatives were interviewed between 1/21/20 and 1/22/20, none voiced concerns regarding the treatment their family member receive from the facility. One resident had been in the facility since 2012 and her representative said she did not have any concern with the care and treatment the resident received in the facility.

It could not be determined that residents were subjected to abuse and punishment, Therefore, the allegation was unsubstantiated, and no deficient practice as identified.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: Residents' family members are not notified when residents develop pressure ulcers while in the facility.

Findings #2: The Wound Nurse was interviewed on 1/24/20 at 9:21 AM. The Wound Nurse stated residents with skin infection, pressure ulcer or any skin issues that would require her assessment and attention were referred to her by staff.

Fifteen residents' records, including 12 active records (records of residents who were currently residing at the facility) and three closed records (records of residents who had been discharged from the facility) were reviewed. One closed record documented a resident was admitted to the facility on 11/20/18, with multiple purpuras on top of his right hand and both forearms related to intravenous punctures when he was in the hospital. A 3x3 skin tear was also noted on top of his left forearm and it was covered with Tegaderm. The resident's weekly skin checks documented the skin tear and multiple purpuras that were fading. Documentation of pressure ulcers was not present in the resident's record and the resident's Nursing Discharge Assessment, dated 12/7/18, documented his skin condition was good.

The Wound Nurse was interviewed on 1/24/20 at 9:21 AM. The Wound Nurse said the resident was not referred to her for any skin issues.

It could not be determined that residents' family members were not notified when residents develop pressure ulcers while in the facility. Therefore, the allegation was unsubstantiated, and no deficient practice as identified.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #3: The resident was discharged home prematurely.

Findings #3: The Physical Therapist (PT) was interviewed on 1/23/20 at 8:29 AM, and said they completed a home evaluation for the resident and it went well. The resident was able to use his walker and did well on the stairs. The PT also stated the resident progressed from contact guard assist (wherein the resident needed a light physical contact from staff member to steady) to stand by assist (no physical contact from staff member).

The Licensed Social Worker (LSW) was interviewed on 1/23/20 at 9:36 AM. The LSW said both the Physical Therapist (PT) and Occupational Therapist (OT) recommended for the resident to go to assisted living. The LSW said she spoke to the resident's medical insurance on approximately 11/25/18 to extend his stay in the facility as he was not ready to go home. The medical insurance agreed for the resident to stay until 12/7/18. The LSW said she also spoke to the resident's daughter approximately on 12/4/18, and informed her of the PT and OT recommendation. The LSW said talked to the resident about going to the assisted living after his physical therapy was completed, but the resident said "No." The resident stated he just wanted to go home. The resident's record also documented his goal was to go home.

Bonnie Sorensen, Administrator
March 25, 2020
Page 4 of 4

A physician's discharge order, dated 12/5/18, documented the resident to be discharge home with home health and to have a follow-up with the physician within two weeks of discharge.

The facility's Grievance file and Resident Council minutes from November 2018 to January 2020 were reviewed. There were no concerns documented in the Grievance file or in the Resident Council minutes related to residents being discharged prematurely from the facility.

It could not be determined that the resident was prematurely discharged from the facility. Therefore the allegations was unsubstantiated, and no deficient practice was identified.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

As none of the allegations were substantiated, no response is necessary.

If you have any questions, comments or concerns regarding this matter, please contact Laura Thompson, RN, or Belinda Day, RN, Supervisors, Long Term Care Program at (208) 334-6626, Option #2.

Sincerely,



BELINDA DAY, RN, Supervisor
Long Term Care Program

BD/ac