



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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DAVE JEPPESEN – Director

TAMARA PRISOCK—ADMINISTRATOR  
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3232 Elder Street  
P. O. Box 83720  
Boise, Idaho 83720-0009  
PHONE: (208) 334-6626  
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February 21, 2020

R. Ryan Beckman, Administrator  
Grangeville Health & Rehabilitation Center  
410 East North Second Street  
Grangeville, ID 83530-2258

Provider #: 135080

Dear Mr. Beckman:

On **February 6, 2020**, a survey was conducted at Grangeville Health & Rehabilitation Center by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

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

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

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 **March 2, 2020**. Failure to submit an acceptable PoC by **March 2, 2020**, may result in the imposition of penalties by **March 24, 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 **March 12, 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 **May 6, 2020**. A change in the seriousness of the deficiencies on **March 22, 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 **May 6, 2020** includes the following:

Denial of payment for new admissions effective **May 6, 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 **August 6, 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 Seattle or the State Medicaid Agency beginning on **May 6, 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 be found on the Internet at:

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<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 **March 2, 2020**. If your request for informal dispute resolution is received after **March 2, 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/lj

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

PRINTED: 03/12/2020  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135080</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/06/2020</b>
NAME OF PROVIDER OR SUPPLIER  <b>GRANGEVILLE HEALTH &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>410 EAST NORTH SECOND STREET GRANGEVILLE, ID 83530</b>		
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F 000	INITIAL COMMENTS  The following deficiencies were cited during the federal recertification and complaint survey conducted from February 3, 2020 to February 6, 2020.  The surveyors conducting the survey were:  Presie C. Billington, RN, Team Coordinator Karen George, RN  Abbreviations:  CNA = Certified Nursing Assistant DON = Director of Nursing GDR = Gradual Dose Reduction LPN = Licensed Practical Nurse MDS = Minimum Data Set RN = Registered Nurse	F 000			
F 552 SS=D	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5)  §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including:  §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition.  §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care.  §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of	F 552		3/2/20	

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

TITLE

(X6) DATE

Electronically Signed

03/02/2020

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 552	<p>Continued From page 1</p> <p>proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff interview, it was determined the facility failed to ensure informed consent was obtained prior to initiation of medications for 2 of 5 residents (#5 and #32) who were reviewed for unnecessary medications. This deficient practice placed residents at risk of receiving medications without knowledge of the risks and benefits associated with the medications and the right to refuse the medications. Findings include:</p> <p>a. Resident #5 was admitted to the facility on 10/25/18, with multiple diagnoses including dementia.</p> <p>Resident #5's physician's order included Donepezil (used to treat confusion related to dementia) 5 mg at bedtime, started on 10/25/18.</p> <p>Resident #5's record did not include documentation he consented to the Donepezil, or was informed about beneficial effects and possible side effects of the medication.</p> <p>b. Resident #32 was admitted to the facility on 1/30/17, with multiple diagnoses including post-concussion syndrome (a condition associated with a head injury causing symptoms such as headaches and dizziness), and anxiety disorder.</p> <p>Resident #32's physician's order included Donepezil 10 mg at bedtime, started on 1/30/17.</p>	F 552	<p>F-552</p> <p>Resident Specific:</p> <p>Resident's #5 and #32 now have signed consent forms including beneficial effects and possible side effects of Donepezil.</p> <p>Other Residents:</p> <p>Please see systemic changes.</p> <p>Systemic Changes:</p> <p>Educate nursing staff on the need for consent forms for Donepezil. All residents prescribed Donepezil will sign consent forms including beneficial effects and possible side effects on admit or when prescribed by their physician during their stay.</p> <p>Monitors:</p> <p>DON or designee will review all residents weekly X 3 and Monthly X 2 to ensure proper consent and notifications are being provided.</p> <p>DON or designee will report findings at QA meeting and will make changes to the above plan of correction as needed.</p>		

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F 552	Continued From page 2	F 552	Date of Compliance: March 2nd 2020		
F 684 SS=D	<p>Resident 32's record did not include documentation she consented to the Donezepil, or was informed about beneficial effects and possible side effects of the medication.</p> <p>On 2/5/20 at 4:17 PM, Administrator #2 said the facility did not obtain consents for Donezepil.</p> <p>Quality of Care 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 record review, policy review and staff interview, it was determined the facility failed to ensure professional standards of practice were followed when a) blood pressure medications were held when a resident's pulse was outside of ordered parameters for 1 of 5 residents (Resident #12) reviewed for unnecessary medications; and b) staff failed to dispose controlled medications consistent with the facility's policy to prevent drug diversion for 2 of 2 licensed nurses (LPN #1 and LPN #2) who were interviewed during medication cart inspection. These failed practices placed Resident #12 at risk of dangerously low blood pressure, and created the potential for harm for each of the 38 residents residing in the facility if controlled medications were diverted and</p>	F 684	<p>F-684</p> <p>(1)</p> <p>Resident Specific:</p> <p>Resident #12 <input type="checkbox"/> Metoprolol is being administered per medication parameters and has surfed no ill effect.</p> <p>Other Residents:</p> <p>Please see systemic changes.</p> <p>Systemic Changes:</p>	3/6/20	

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F 684	<p>Continued From page 3</p> <p>residents did not receive medications as ordered. Findings include:</p> <p>1. Resident #12 was admitted to the facility on 4/10/15, with multiple diagnoses including hypertension (high blood pressure).</p> <p>Resident #12's physician orders included the following:</p> <p>* Metoprolol (medication to lower blood pressure) 12.5 mg twice a day. Hold the medication if Resident #12's systolic blood pressure (a measurement of the amount of blood pressure in arteries during the contraction of the heart muscle) was less than 90 or if her pulse rate was less than 60.</p> <p>This order was not followed.</p> <p>Resident #12's MAR documented her pulse rate was less than 60 and Metoprolol was administered on:</p> <p>* 1/8/20 (pulse was 56) * 1/13/20 (pulse was 56) * 1/14/20 (pulse was 58)</p> <p>On 2/5/20 at 2:27 PM, the DON reviewed Resident #12's MAR and said Metoprolol was administered to Resident #12 and it should have been withheld when her pulse rate was less than 60.</p> <p>2. The facility's policy and procedure for Destruction of Medications, dated 2/7/18, documented the following:</p>	F 684	<p>Nursing staff in-serviced on proper administration of medications within ordered parameters and proper notation regarding these medications.</p> <p>Monitors:</p> <p>DON or designee will review medication administration of 3 resident's weekly X 3 and monthly X 2 to ensure medications are being given or held within ordered parameters.</p> <p>DON or designee will report findings at QA meeting and will make changes to the above plan of correction as needed.</p> <p>Date of Compliance: March 2nd 2020</p> <p>(2)</p> <p>Resident Specific:</p> <p>N/A</p> <p>Other Residents:</p> <p>N/A</p> <p>Please see systemic changes.</p> <p>Systemic Changes:</p> <p>Nursing staff in-serviced on proper destruction of medications. Facility is now using a Drug Buster disposal system to destroy controlled medications.</p> <p>Monitors:</p>		

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F 684	<p>Continued From page 4</p> <ul style="list-style-type: none"> <li>* Two licensed nurses or one licensed nurse and one registered pharmacist destroyed controlled medications.</li> <li>* If prompt destruction of controlled medications was not feasible, the medications were retained in a securely locked location with restricted access until destroyed by the DON and one licensed nurse or registered pharmacist.</li> <li>* Staff were not to flush medicines down the sink or toilet unless specific labeling information instructed them to do so.</li> <li>* The controlled medication was removed from the original container and mixed with an undesirable substance such as used coffee grounds, charcoal, or kitty litter. Staff were to place the mixture in an impermeable nondescript container and put it in the facility dumpster for regular trash removal.</li> <li>* If the above destruction was not immediately feasible, it was permissible to flush controlled medications unless the specific labeling information indicated flushing was contraindicated.</li> </ul> <p>This policy was not followed:</p> <p>On 2/5/20 at 5:10 PM, during the inspection of 100 Hall Medication Cart, LPN #1 said controlled medications were destroyed or wasted in the presence of two licensed nurses. LPN #1 said both nurses signed and dated the narcotic log book for the controlled medications to be destroyed or wasted. LPN #1 said if there was only one tablet of controlled medication, he</p>	F 684	<p>DON or designee will conduct 3 random nursing interviews weekly X3 and Monthly X2 to ensure nurses are following proper disposal of controlled medications.</p> <p>DON or designee will report findings at QA meeting and will make changes to the above plan of correction as needed.</p> <p>Date of Compliance: March 2nd 2020</p>		

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F 684	Continued From page 5 placed it in the sharps container attached to the medication cart. LPN #1 said if there were multiple tablets of controlled medication to be destroyed, he put them in a plastic container, added hot water, and let them dissolve. He said after the controlled substances dissolved, he put them down the sink in the presence of another licensed nurse.  On 2/5/20 at 5:15 PM, LPN #2 said controlled medications were wasted or destroyed in the presence of two licensed nurses. LPN #2 said both nurses signed and dated the narcotic log book. LPN #2 said she put the wasted controlled medications in the sharps container.  On 2/5/20 at 5:19 PM, the DON said controlled medications were dissolved in water and the mixture was flushed in the toilet. The DON said controlled medications were not to be placed in sharps containers.	F 684			
F 758 SS=D	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---	F 758		3/6/20	

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F 758	<p>Continued From page 6</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 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 interview and record review, it was determined the facility failed to ensure residents receiving psychotropic medications had clear indications for use of the medications and</p>	F 758	<p>F-758</p> <p>Resident Specific:</p>		

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F 758	<p>Continued From page 7</p> <p>clinical rationale supporting the continued use of the medications. This was true for 1 of 5 residents (Resident #12) whose records were reviewed for unnecessary medications. This deficient practice had the potential for harm if residents received psychotropic medications that were unwarranted and used for excessive duration. Findings include:</p> <p>Resident #12 was admitted to the facility on 4/10/15, with multiple diagnoses including depression and anxiety.</p> <p>Resident #12's quarterly MDS assessment, dated 11/25/19, documented she was cognitively intact and received anti-psychotic and anti-depressant medications in the past 7 days.</p> <p>Resident #12's physician order report for 2/1/20 to 2/29/20, included the following:</p> <p>* Zoloft (anti-depressant medication) 50 mg tablet once a day for depression.</p> <p>* Risperdal (anti-psychotic medication) 1 mg twice a day for acute psychotic episodes.</p> <p>* Diphenhydramine (anti-histamine medication also used to treat insomnia) 50 mg at bedtime for insomnia.</p> <p>a. Three pharmacy reviews addressed to Resident #12's physician, dated 5/29/19, 9/30/19, and 12/31/19, documented the Zoloft and Risperdal medications were reviewed and the following concerns were identified:</p> <p>* A GDR was indicated for Zoloft. The pharmacy</p>	F 758	<p>Resident #12 physician has reviewed Zoloft, Risperdal, and Diphenhydramine prescriptions and addressed indications for use and risks vs benefits of the medication.</p> <p>Other Residents:</p> <p>Please see systemic changes.</p> <p>Systemic Changes:</p> <p>Physicians notified that residents receiving psychotropic medications must have clear indications for use of the medications and clinical rationale supporting the continued use of the medications when a GDR is indicated by the pharmacist. If the physician feels that the GDR is contraindicated, they will be required to write a risk vs benefits statement. Any GDR request not addressed appropriately will be referred to the Medical Director. Educated all staff involved in the GDR process to identify GDRs not meeting requirements so that they can be addressed appropriately.</p> <p>Monitors:</p> <p>DON or designee will review all GDR requests to ensure physician is appropriately addressing all requests weekly X 3 and Monthly X 2 to ensure the GDR process is being followed appropriately.</p> <p>DON or designee will report findings at</p>		

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F 758	<p>Continued From page 8</p> <p>reviews stated if there was no change to the Zoloft dose, the physician was to write a brief risk versus benefit statement for the continued need of the medication.</p> <p>Resident #12's physician's responses to the pharmacy reviews of Zoloft, documented "Stable no change."</p> <p>* Risperdal was not indicated for geriatric use and a GDR was indicated. The pharmacy reviews stated if there was no change to the Risperdal dose, the physician was to write a brief risk versus benefit statement for the continued need of the medication.</p> <p>Resident #12's physician's responses to the pharmacy reviews of Risperdal documented "Stable no change."</p> <p>b. A pharmacy review addressed to Resident #12's physician, dated 5/29/19, documented the daily dosage of Diphenhydramine and duration of usage was greater than recommended guidelines, and a GDR was recommended. The pharmacy review stated if there was no change to the Diphenhydramine dose, the physician was to write a brief risk versus benefit statement for the continued need of the medication.</p> <p>Resident #12's pharmacy reviews to the physician, dated 8/29/19 and 12/31/19, documented Resident #12 was receiving Diphenhydramine routinely. The pharmacist recommended the physician consider changing the order to as needed for insomnia, and if long term management for insomnia was needed to</p>	F 758	<p>QA meeting and will make changes to the above plan of correction as needed.</p> <p>Date of Compliance: March 6th 2020</p>		

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

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F 758	Continued From page 9 consider using Trazadone or Mirtazapine (medications used to treat insomnia) as potential alternatives to hypnotic agents. The pharmacist also stated the use of hypnotics should generally be limited to 7-10 days.  Resident #12's physician's responses to the pharmacy reviews of Diphenhydramine documented "Stable no change."  Resident #12's physician responses to the pharmacy reviews of Zolof, Risperdal, and Diphenhydramine did not include clinical rationales of risks versus benefits for the continued use of the medications or for continued use at the current doses.  On 2/6/20 at 10:35 AM, the DON reviewed Resident #12's record and said she would look for the physician's risk versus benefits statements for Resident #12's medications.  On 2/6/20 at 10:46 AM, Administrator #1 said they did not find the physician's statement of risk versus benefits for Resident #12's medications. The Administrator said they only had the physician's statement the resident was stable.	F 758			
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	F 812		3/2/20	

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F 812	<p>Continued From page 10 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: Based on observation, policy review, and staff interview, it was determined the facility failed to ensure food was prepared and served under sanitary conditions when staff members' hair was observed not properly restrained in a hairnet. This failure created the potential for each of the 38 residents residing at the facility to be exposed to food contamination and potential disease-causing pathogens. Findings include:</p> <p>The facility's policy and procedure for Food Handling, dated 6/13/18, directed food handlers to wear hairnets or caps to effectively keep hair from contacting exposed food, clean equipment, utensils and linens.</p> <p>The 2017 Food and Drug Administration Food Code, Chapter 2, regarding hygienic practices and hair restraints, documented "Food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food, clean equipment,</p>	F 812	<p>F-812</p> <p>Resident Specific:</p> <p>Please see systemic changes.</p> <p>Other Residents:</p> <p>Please see systemic changes.</p> <p>Systemic Changes:</p> <p>Dietary staff have been in-serviced on the policy and procedure regarding proper use of acceptable head coverings to contain their hair.</p> <p>Monitors:</p> <p>Dietary Manager or designee will conduct random inspections for each working shift weekly X 3 and Monthly X 2 to ensure proper head coverings are being utilized</p>		

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F 812	<p>Continued From page 11</p> <p>utensils, and linens and unwrapped single-service and single-use articles."</p> <p>On 2/3/20 at 11:35 AM, Dietary Staff (DS) #2 and the Dietary Manager (DM) were observed in the kitchen as they prepared food for the lunch meal. DS #2 wore her hair up in a pony tail on the top of her head with a large flower attached to the pony tail, and loose hair flowed down the back of her head and neck. DS #2 wore a hairnet over her pony tail. DS #2's hairnet did not cover the hair that flowed down the back of her head and neck, and her hair was exposed from root to tip. The DM wore a scarf which was tied to her head. The DM's scarf did not cover her bangs which flowed freely from root to tip. The DM and DS #2 wore their hair in this manner throughout the preparations and delivery of food for the lunch meal.</p> <p>On 2/4/20 at 8:10 AM, DS #2 and the DM were observed in the kitchen as they prepared food for the breakfast meal. DS #2 had her hair up in a pony tail with a large flower attached to the pony tail. DS #2 wore a hairnet around her pony tail and flower and down slightly on the back of her head but above the level of her ears. There was a significant amount of loose hair that was not contained in the pony tail or the hairnet. The DM wore a scarf which was tied to her head in alignment with her ears. The DM's bangs were not covered and flowed freely.</p> <p>On 2/4/20 at 12:06 PM, the DM said she was not positive about the facility's policy requirement for restraining hair while working in the kitchen. The DM said she believed "all of the hair" needed to be covered.</p>	F 812	<p>Dietary Manager or designee will report findings at QA meeting and will make changes to the above plan of correction as needed.</p> <p>Date of Compliance: March 2nd 2020</p>		

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F 880 SS=E	<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 possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of</p>	F 880		3/2/20	

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F 880	<p>Continued From page 13</p> <p>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 by: Based on observation, staff interview, and policy review, it was determined the facility failed to ensure staff performed proper hand hygiene and appropriate peri-care during resident cares. This was true for 1 of 4 residents (Resident #3) who was observed during resident cares. The deficient practice placed residents at risk of</p>	F 880	<p>F-880</p> <p>Resident Specific:</p> <p>Resident #3 suffered no ill effects.</p> <p>Other Residents:</p>		

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F 880	<p>Continued From page 14 infection from cross-contamination. Findings include:</p> <p>The facility's policy and procedure for Handwashing, dated 6/13/18, directed staff to wash their hands before applying and removing gloves, before handling clean supplies or equipment, and before and after contact with non-intact skin, mucous membranes, blood, or any moist body fluid, even if gloves were worn during contact.</p> <p>The facility's policy and procedure for Incontinent Care While in Bed, dated 2/27/18, documented staff were to:</p> <ul style="list-style-type: none"> <li>* Remove the incontinent brief from the patient by rolling the brief/pad toward the inside soiled area, and remove the brief from front to back containing the fecal matter as much as possible</li> <li>* Cleanse the skin of patient from front to back and clean to dirty using incontinent wipes</li> <li>* Replace the soiled brief with a fresh brief or pad</li> <li>* Remove their gloves and discard them into a designated container</li> <li>* Wash and dry hands thoroughly</li> </ul> <p>On 2/4/20 at 8:34 AM, CNA #1 and CNA #2 were observed providing pericare to Resident #3. CNA #1 and CNA #2 repositioned Resident #3 to her left side, rolled the soiled incontinent brief and placed a clean incontinence brief under Resident #3's left hip. CNA #2 then wiped the feces from Resident #3's buttocks. CNA #1 and CNA #2 then rolled Resident #3 onto her back slightly to her right side to remove the soiled incontinence brief and then unrolled the clean incontinence brief.</p>	F 880	<p>Please see systemic changes</p> <p>Systemic Changes:</p> <p>Nursing staff and CNAs in-serviced on proper hand hygiene and peri-care.</p> <p>Monitors:</p> <p>DON or designee will observe 3 staff perform peri-care to ensure proper policy and procedures being followed weekly X 3 and Monthly X 2</p> <p>DON or designee will report findings at QA meeting and will make changes to the above plan of correction as needed.</p> <p>Date of Compliance: March 2nd 2020</p>		

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F 880	<p>Continued From page 15</p> <p>Resident #3 was repositioned on her back with the clean incontinence brief placed under her buttocks. CNA #2 continued providing pericare to Resident #3 using the same soiled gloves she used to wipe Resident #3's feces from her rectal area. CNA #2 then proceeded to clean Resident #3's genitalia using the same soiled gloves. CNA #2 then pulled the front side of the clean incontinence brief and fastened the tape.</p> <p>CNA #2 did not change her gloves or sanitize her hands between dirty and clean tasks during pericare. CNA #2 also did not fully clean Resident #3's peri area prior to placing her on the clean incontinence brief.</p> <p>On 2/4/20 at 8:47 AM, CNA #1 said "Normally we would not have continued to clean her after she was on the clean pad." CNA #1 said they were trying not to roll Resident #3 more than they had to roll her because she was in pain.</p> <p>On 2/6/20 at 9:12 AM, the DON said her expectation was for staff to clean both sides of a resident's periaarea prior to applying new incontinence brief. The DON said the way the staff provided pericare to a resident may vary slightly depending on the resident's needs. The DON also said she did not think it was necessary for the staff to remove their gloves or sanitize their hands between dirty and clean tasks.</p> <p>On 2/6/20 at 2:10 PM, during the follow-up interview, the DON said the CNAs were to wash their hands every time they removed their gloves. The DON said the CNAs should have wiped Resident #3's front side and then cleansed her back side. The DON also stated it was okay for</p>	F 880			

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F 880	Continued From page 16 the CNA to apply the clean incontinence brief before they removed the soiled gloves or sanitized their hands.	F 880			



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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March 25, 2020

R. Ryan Beckman, Administrator  
Grangeville Health & Rehabilitation Center  
410 East North Second Street  
Grangeville, ID 83530-2258

Provider #: 135080

Dear Mr. Beckman:

On **February 3, 2020** through **February 6, 2020**, an unannounced on-site complaint survey was conducted at Grangeville Health & Rehabilitation Center. The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00008207**

**Allegation #1:** The facility does not send residents to the hospital when they experience a change of condition and hospital records are not provided to resident representatives.

**Findings #1:** The Director of Nursing (DON) and the Administrator were interviewed on 2/5/20 at 2:07 PM, the DON said anytime a resident had a change of condition, the physician and residents' representative would be notified. The DON also said if they believed the resident's condition needed to be sent to the hospital they would send the resident even without the physician's order no matter what the resident's Physician Scope of Treatment (POST) was. The DON also stated if the family requested for a resident to be sent to the hospital they would send the resident to the hospital.

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 staff noted the resident having difficulty answering questions or talking to the staff. The resident's extremities were noted to be extremely weak and flaccid. A urine analysis was

obtained and sent to the hospital for testing. The resident's physician was updated of her condition and she was placed on alert charting. The resident's record documented she was offered foods and fluids, but she refused and stayed in bed. The resident's representative was notified of her condition. When the resident's representative arrived in the facility, they requested for the resident to be sent to the hospital. The resident's record documented she was sent to the hospital in 4/2/19 and was readmitted to the facility on 4/8/19. The resident's hospital final report which was faxed to the facility on 4/8/19, included her history, physical exam, laboratory results and list of her medications. There was no documentation that the resident had been admitted to the hospital prior to 4/2/19.

The facility's Grievance file and Resident Council minutes from January 2019 through February 2020 were reviewed. There were no concerns documented in the Grievance file and Resident Council regarding residents not being sent to the hospital when needed. There was no grievance regarding medical records not being provided to the residents or their representatives.

Six residents were interviewed individually on 2/3/20 and 2/4/20. The residents stated they had no concerns with the care they received from the facility. The residents did not voice concerns regarding their medical records not being provided to them or to their representatives when asked for it.

Three family representatives were interviewed, and none voiced concern regarding the care their family received in the facility. The family representatives said they believed if their family member needed medical attention the facility would send them to the hospital. The residents' representatives believed the facility would provide the residents' medical record if they request for it.

It could not be determined that the facility did send residents to the hospital when they experience a change of condition or that records were not provided to resident representatives. Therefore, the allegation was unsubstantiated, and no deficient practice was identified.

**Conclusion:** Unsubstantiated. Lack of sufficient evidence.

**Allegation #2:** Residents are overmedicated.

**Findings #2:** The facility's Grievance file and Resident Council minutes from January 2019 through February 2020 were reviewed. There were no concerns documented in the Grievance file and Resident Council regarding residents being over medicated.

A dining observation was completed on 2/3/20, none of the residents eating lunch in the dining room were observed to be sleepy or appeared to be over medicated.

Six residents attended the group interview with surveyors on 2/4/20 at 9:55 Am. None of the residents voiced concern regarding their medications.

Three family representatives were interviewed, and none voiced concern regarding the care their family received in the facility.

Six residents' records, including five active records (records of residents who were currently residing at the facility) and one closed record (records of resident who had been discharged from the facility) were reviewed for unnecessary medications. One of the six records documented a resident, admitted to the facility on 4/10/15, was receiving anti-psychotic and anti-depressant medications and a medication to help her sleep. Three pharmacy reviews dated 5/29/19, 9/30/19, and 12/31/19, documented a gradual dose reduction was indicated for the anti-psychotic and anti-depressant medications. The pharmacy review, dated 5/29/19, also recommended a gradual dose reduction for the sleep medication and the pharmacy reviews dated 8/29/19 and 12/31/19, documented a change to the sleep medication being used should be considered. However, the resident's medications were not changed. The physician's responses to the pharmacy reviews did not include clinical rationales of risks versus benefits for the continued use of the medications or for continued use at the current doses.

On 2/6/20 at 10:35 AM, the Director of Nursing (DON) reviewed the resident's record and said she would look for the physician's risk versus benefits statements for the resident's medications.

On 2/6/20 at 10:46 AM, the Administrator said they did not find the physician's statement of risk versus benefits for the resident's medications. The Administrator said they only had the physician's statement the resident was stable.

It could not be determined that residents were overmedicated. Therefore, the allegation was unsubstantiated. However, it was determined that the facility failed to ensure the clinical rationale supporting the continued use psychotropic medications was clearly documented in each resident's record. Therefore, deficient practice was identified and cited at F758.

**Conclusion:** Unsubstantiated. Lack of sufficient evidence.

**Allegation #3:** The facility failed to provide adequate supervision to prevent falls.

**Findings #3:** The facility's Incident's and Accidents (I&A) Report, dated January 2019 to May 2019, was reviewed. One closed record documented the resident had a fall prevention plan in place and the resident's nursing notes documented she was also placed within line of sight of staff as she frequently leaned forward to reach for something on the floor.

R. Ryan Beckman, Administrator  
March 25, 2020  
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During the investigation, staff were observed to transfer residents in a safe and appropriate manner, including two-person assistance transfers. Three residents' beds were observed in a low bed position while the residents were lying in their beds and fall mats were also observed in placed on both sides of their beds.

Three family representatives were interviewed, and said they believed the facility provided the necessary care needed by their family in the facility.

It could not be determined that the facility failed to provide adequate supervision to prevent falls. Therefore, the allegation 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