



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  
BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, Idaho 83720-0009  
PHONE: (208) 334-6626  
FAX: (208) 364-1888  
E-mail: [fsb@dhw.idaho.gov](mailto:fsb@dhw.idaho.gov)

February 20, 2019

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

Provider #: 135080

Dear Mr. Beckman:

On **February 12, 2019**, we conducted an on-site revisit to verify that your facility had achieved and maintained compliance. We presumed, based on your allegation of compliance, that your facility was in substantial compliance as of **January 25, 2019**. However, based on our on-site revisit we found that your facility is not in substantial compliance with the following participation requirements:

- **F609 -- S/S: D -- 483.12(c)(1)(4) -- Reporting Of Alleged Violations**
- **F761 -- S/S: D -- 483.45(g)(h)(1)(2) -- Label/store Drugs And Biologicals**
- **F880 -- S/S: D -- 483.80(a)(1)(2)(4)(e)(f) -- Infection Prevention & Control**

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

After each deficiency has been answered and dated, the administrator should sign the Form CMS-2567 and State Form (if applicable), Statement of Deficiencies and Plan of Correction in the spaces provided and return the original(s) to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **March 4, 2019**.

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

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

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

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

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

As noted in the Bureau of Facility Standards' letter of **November 20, 2018**, following the survey of **October 26, 2018**, we have already made the recommendation to the Centers for Medicare and Medicaid Services (CMS) for a Civil Money Penalty, Denial of Payment for New Admissions effective **January 26, 2019** and termination of the provider agreement on **April 26, 2019**, if substantial compliance is not achieved by that time.

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

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

R. Ryan Beckman, Administrator  
February 20, 2019  
Page 3 of 3

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You may also contest scope and severity assessments for deficiencies, which resulted in a finding of SQC or immediate jeopardy. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

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

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

- BFS Letters (06/30/11)

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

This request must be received by **March 4, 2019**. If your request for informal dispute resolution is received after **March 4, 2019**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, comments or concerns, please contact Debby Ransom, RN, RHIT, Bureau Chief at (208) 334-6626, option 5.

Sincerely,

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

dr/lj  
Enclosures

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

PRINTED: 03/01/2019  
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>R</b> <b>02/12/2019</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>		
(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 revisit survey conducted February 11, 2019 to February 12, 2019.  The surveyors conducting the survey were:  Teresa Kobza, RDN, LD, Team Coordinator Geri Wolfe, RN  Abbreviations:  ADL = Activities of Daily Living CNA = Certified Nursing Assistant DON = Director of Nursing LPN = Licensed Practical Nurse RN = Registered Nurse	{F 000}			
{F 609} SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4)  §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:  §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care	{F 609}		2/25/19	

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

TITLE

(X6) DATE

Electronically Signed

02/25/2019

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135080</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R</b> <b>02/12/2019</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>		
(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 609}	<p>Continued From page 1 facilities) in accordance with State law through established procedures.</p> <p>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interview, record review, policy review, and review of reportable incidents, it was determined the facility failed to ensure injuries of unknown origin were reported to the Administrator within 24 hours for 1 of 3 residents (Resident #16) reviewed for abuse/neglect. This had the potential to adversely affect all residents residing in the facility. The deficient practice created the potential for harm if abuse was not reported and investigated completely. Findings include:</p> <p>The facility's Abuse Reporting policy, dated 3/12/18, documented an injury of unknown origin was an injury whose source was not observed by any person or the source of the injury could not be explained by the resident; and, the injury includes bruising on the head, neck, or trunk, fingerprint bruises anywhere on the body, lacerations, sprains, or fractured bones. The policy documented minor bruising or skin tears did not need to be reported to the state survey agency. The policy documented injuries of unknown origin and minor bruising "must be immediately reported" to the facility Administrator within 24 hours.</p>	{F 609}	<p>F-609</p> <p>Resident Specific:</p> <p>Resident #16 investigation submitted and complete. Root cause identified and resident free from abuse and neglect.</p> <p>Other Residents:</p> <p>A&amp;I reports meeting reporting requirements will be submitted verbally to Administrator and DON within 24 hrs.</p> <p>Systemic Changes:</p> <p>Nursing staff in serviced by DON and VP of Clinical Services and then preformed return demonstrations at a physical mock scenario station to confirm they understood policy/procedure.</p> <p>Monitors:</p> <p>Administrator or designee will review all reportable incidents weekly times 4</p>		

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

PRINTED: 03/01/2019  
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>R</b> <b>02/12/2019</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</b> <b>GRANGEVILLE, ID 83530</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{F 609}	Continued From page 2  This policy was not followed.  Resident #16 was admitted to the facility on 9/2/16, with diagnoses including dementia.  A quarterly Minimum Data Set assessment, dated 11/28/18, documented Resident #16 had severe cognitive impairment and required the assistance of one to two staff personnel with her ADLs.  An Incident and Accident (I&A) report, dated 2/7/19 at 4:00 PM, documented Resident #16 was found with redness, bruising and edema to her right forearm and hand and it was unknown how she acquired these injuries. The I&A report was documented as reviewed by the DON and Administrator on 2/11/19, four days later.  On 2/11/19 at 3:39 PM, the Administrator stated he was unaware of Resident #16's injury of unknown origin until the morning of 2/11/19. The Administrator stated the DON started reviewing and interviewing staff.  On 2/11/19 at 3:45 PM, the DON stated she was made aware of Resident #16's injury of unknown origin the morning of 2/11/19. The DON stated she started her investigation as soon as she was made aware of the incident.  On 2/11/19 at 4:50 PM, RN #2 stated she completed an I&A report for Resident #16's injury of unknown origin, and she placed the completed report into the DON's mailbox. RN #2 stated she did not verbally report the injury to the Administrator or DON within 24 hours.	{F 609}	monthly times 3 to ensure reporting requirements were met timely.  Administrator or designee will report findings at QA meeting and will make changes to the above plan of correction as needed.  Date of Compliance: February 25th 2019		

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>R</b> <b>02/12/2019</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</b> <b>GRANGEVILLE, ID 83530</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{F 761} SS=D	<p>Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)</p> <p>§483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>§483.45(h) Storage of Drugs and Biologicals</p> <p>§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure medications were properly labeled which effected 1 of 9 residents (Resident #145) observed during medication pass. This failure had the potential for Resident #145 to receive the wrong dosage of Coumadin. Findings include:  Resident #145's record included a physician's</p>	{F 761}	<p>F-761</p> <p>Resident Specific:</p> <p>Resident #145 labeling of medications reviewed and match physician orders.</p> <p>Other Residents:</p>	2/28/19	

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>R</b> <b>02/12/2019</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>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{F 761}	<p>Continued From page 4</p> <p>order, dated 1/30/19 at 3:45 PM, which documented Coumadin was changed from 5 mg daily to 5 mg every other day.</p> <p>The Medication Administration Record, dated 2/1/19 to 2/11/19, documented, Resident #145 received Coumadin 5 milligrams (mg) every other day. The pharmacy had sent a new dose pack of the Coumadin with a label for the new dose. Facility staff continued to administer the Coumadin from the pack with the discontinued dose.</p> <p>On 2/11/19 at 4:15 PM, LPN #1 administered Coumadin 5 mg by mouth to Resident #145. The directions on the pharmacy label stated, "Take one tablet by mouth every day." The "every day" on the label was scribbled over and "QOD [every other day]" was handwritten with a pen.</p> <p>LPN #1 said the dosage was changed recently and the pharmacy label was not changed. LPN #1 said handwriting on a pharmacy label was not acceptable. LPN #1 said when there was a change in a resident's medication dosage the order should be sent to the pharmacy and a new medication was sent with the appropriate label.</p> <p>On 2/11/19 at 5:50 PM, the DON said if an order for a medication dosage was changed the nurses should fax the order to the pharmacy and obtain a new pharmacy label or dose pack. She said the dose pack with the wrong label should be removed from the medication cart. The DON said the facility did not have a written policy for labeling of medications.</p>	{F 761}	<p>All current resident's medications have been reviewed to ensure they match physician orders</p> <p>Systemic Changes:</p> <p>All nursing staff in-serviced on proper identification and administration of medications. Reviewed new policy and procedure for on acquiring new medications from pharmacy. Nursing staff preformed return demonstrations to DON and VP of clinical services at physical mock scenario station to confirm they understood policy/procedure.</p> <p>Monitors:</p> <p>DON or designee will weekly times 4 and monthly times 3 observe medication pass to ensure proper identification of medication and labeling P&amp;P being followed.</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: February 28th 2019</p>		
{F 880} SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	{F 880}		2/25/19	

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>R</b> <b>02/12/2019</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</b> <b>GRANGEVILLE, ID 83530</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{F 880}	Continued From page 5  §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.  §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:  §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;  §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 infections;	{F 880}			

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>R</b> <b>02/12/2019</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>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{F 880}	<p>Continued From page 6</p> <p>(iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (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 (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, Infection Control Program review, policy review, and staff interview, it was determined the facility failed to ensure hand hygiene was performed before and after medication administration and during peri-care. This directly impacted 2 of 6 residents (#16 and #28) reviewed for infection control practices. These failures placed Residents #16 at #28 at</p>	{F 880}	<p>F-880</p> <p>Resident Specific:</p> <p>Residents #16 and #28 have proper handwashing techniques performed and are involved in the comprehensive infection control surveillance plan.</p>		

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>R</b> <b>02/12/2019</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>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{F 880}	<p>Continued From page 7 risk of developing infections. Findings include:</p> <p>The facility's Hand Washing policy, dated 3/12/18, documented staff should perform hand hygiene before donning gloves, before and after the staff came into contact with mucous membranes, skin, moist body fluids, even if gloves were worn, and before and after removing personal protective equipment.</p> <p>On 2/11/19 at 5:00 PM, LPN #1 was observed completing a finger stick blood sugar for Resident #28. LPN #1 removed his gloves and failed to perform hand hygiene after performing the finger stick and before drawing up Resident #28's insulin into a syringe. LPN #1 then entered Resident #28's room, put on a clean pair of gloves without performing hand hygiene, and administered the insulin. LPN #1 said he did not perform hand hygiene after completing the finger stick and before drawing up the insulin.</p> <p>On 2/11/19 at 4:36 PM, CNA #1 and the DON were observed providing peri-care for Resident #16. After assisting Resident #16 with peri-care CNA #1 did not remove her gloves before applying a new incontinence pad and assisting Resident #16 with her pants. CNA #1 left the room to obtain a gait belt with the dirty gloves on her hands. When she returned with the gait belt she removed her gloves and used hand sanitizer as she reentered the room to continue Resident #16's transfer into her wheelchair.</p> <p>On 2/11/19 at 4:45 PM, CNA #1 stated she did not remove her gloves or perform hand hygiene after she completed Resident #16's peri-care.</p> <p>On 2/12/19 at 8:45 AM, The DON stated CNA #1</p>	{F 880}	<p>Other Residents:</p> <p>Licensed Staff have been in serviced and performed return demonstrations on how to perform proper handwashing techniques and follow the comprehensive infection control surveillance program.</p> <p>Systemic Changes:</p> <p>Nursing staff in serviced and preformed return demonstrations to DON and VP of clinical services at physical mock scenario station to confirm they understood handwashing policy/procedure while administering a blood glucose test.</p> <p>All CNAs in serviced, read and signed handwashing procedure, and DON and Clinical Nurse manger to observe administered cares after signing policy.</p> <p>Monitors:</p> <p>DON or designee will observe three licensed staff to ensure proper handwashing P&amp;P being followed during blood glucose testing weekly times 4 and monthly times 3.</p> <p>DON or designee will observe CNA peri care weekly times 4 and monthly times 3 to ensure proper handwashing P&amp;P being followed.</p> <p>DON or designee will report findings at</p>		

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

PRINTED: 03/01/2019  
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>R</b> <b>02/12/2019</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</b> <b>GRANGEVILLE, ID 83530</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{F 880}	Continued From page 8 should have removed her gloves and performed hand hygiene following peri care.  On 2/12/19 at 9:44 AM, RN #1 said all staff were observed and in-serviced on handwashing in October 2018. RN #1 stated she was responsible for infection control surveillance in the facility.	{F 880}	QA meeting and will make changes to the above plan of correction as needed.  Date of Compliance: February 25th 2019		