



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

March 22, 2019

Christina Thomas, Administrator
Caribou Memorial Living Center
300 South Third West
Soda Springs, ID 83276-1559

Provider #: 135060

Dear Ms. Thomas:

On **March 14, 2019**, a survey was conducted at Caribou Memorial Living 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 one that comprises a pattern 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.

Christina Thomas, Administrator
March 22, 2019
Page 2 of 4

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 **April 1, 2019**. Failure to submit an acceptable PoC by **April 1, 2019**, may result in the imposition of penalties by **April 24, 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; 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 **April 18, 2019 (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 **June 14, 2019**. A change in the seriousness of the deficiencies on **April 28, 2019**, may result in a change in the remedy.

Christina Thomas, Administrator
March 22, 2019
Page 3 of 4

The remedy, which will be recommended if substantial compliance has not been achieved by **June 14, 2019** includes the following:

Denial of payment for new admissions effective **June 14, 2019**. [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 **September 14, 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, 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 Co-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 5; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

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 **June 14, 2019** 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:

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

Christina Thomas, Administrator
March 22, 2019
Page 4 of 4

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 **April 1, 2019**. If your request for informal dispute resolution is received after **April 1, 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 Belinda Day, RN, or Laura Thompson, RN Co-Supervisors, Long Term Care, Bureau at (208) 334-6626, option 3.

Sincerely,



Laura Thompson, RN, Co-Supervisor
Long Term Care
Bureau of Facility Standards

lt/lj

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

PRINTED: 04/12/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135060	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/14/2019
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CARIBOU MEMORIAL LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 300 SOUTH THIRD WEST SODA SPRINGS, ID 83276
---	---

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

F 000	INITIAL COMMENTS The following deficiencies were cited during the federal recertification survey conducted at the facility from March 11, 2019 through March 14, 2019. The surveyors conducting the survey were: Brad Perry, LSW, Team Coordinator Roxie Lacey, RN Survey Abbreviations: CNA = Certified Nursing Assistant CNO = Chief Nursing Officer DNR = Do Not Resuscitate LTCD = Long Term Care Director POST = Physician Orders for Scope of Treatment RN = Registered Nurse	F 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis,	F 550		4/15/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 03/29/2019
---	-------	--------------------------------

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: 135060	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/14/2019
NAME OF PROVIDER OR SUPPLIER CARIBOU MEMORIAL LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 300 SOUTH THIRD WEST SODA SPRINGS, ID 83276		
(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 550	<p>Continued From page 1</p> <p>severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.</p> <p>§483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.</p> <p>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.</p> <p>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review, resident and staff interview, it was determined the facility failed to maintain an environment that enhanced residents' dignity and respect when catheter drainage bags were exposed. This was true for 4 of 4 residents (Resident #6, #7, #12, and #15) who were reviewed for dignity. This practice created the potential for psychosocial harm if residents experienced a lack of self-esteem or embarrassment due to exposed catheter drainage bags. Findings include: The facility's Dignity policy, updated 7/19/17,</p>	F 550	<p>F- 550 Promoting and Maintaining Residents' Dignity with Urinary Catheters.</p> <p>1. Immediate action(s) taken for the resident(s) found to have been affected include: The urinary catheters of RI# 6, 77, 12 and 15 were immediately placed in dignity bags. The staff involved were immediately in-serviced on the proper procedures for maintaining residents' dignity related to urinary catheters.</p> <p>2. Identification of other residents having the potential to be affected was accomplished by:</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135060	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/14/2019
NAME OF PROVIDER OR SUPPLIER CARIBOU MEMORIAL LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 300 SOUTH THIRD WEST SODA SPRINGS, ID 83276		
(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 550	<p>Continued From page 2</p> <p>documented the facility promoted care for residents in a manner, and in an environment, that maintained or enhanced each resident's dignity and respect.</p> <p>a. Resident #15 was admitted to the facility on 12/17/18, with multiple diagnoses including end stage renal disease.</p> <p>Resident #15's care plan documented she had an indwelling catheter for end stage renal disease.</p> <p>On 3/11/19 at 3:50 PM, 4:25 PM, and 5:59 PM, Resident #15 was in her recliner in her room. Her catheter drainage bag was hanging from the side of her garbage can with a hook, and without a privacy cover. At 4:25 PM, Resident #15 had a friend visiting her and the drainage bag did not have a privacy cover. Urine was visible in the drainage bag.</p> <p>On 3/12/19 at 10:28 AM, Resident #15 was in her bed with her catheter drainage bag hanging from her bed. Her drainage bag did not have a privacy cover and it was on the window side of the bed. Urine was visible in the drainage bag. Resident #15 said staff always left the drainage bag uncovered when she was in her room.</p> <p>On 3/12/19 at 1:19 PM, Resident #15 was in her recliner in her room with two visitors. Her catheter drainage bag was hanging from the side of her garbage can without a privacy cover.</p> <p>b. Resident #7 was readmitted to the facility on 3/17/18, with multiple diagnoses including multiple sclerosis (a potentially disabling disease</p>	F 550	<p>The facility has determined that all residents requiring a urinary catheter have the potential to be affected.</p> <p>3. Actions taken/systems put into place to reduce the risk of future occurrence include:</p> <p>An in-service education program was conducted by the Infection Preventionist on 3/20/2019 with all direct care staff addressing urinary catheter dignity bags. Infection Preventionist will include, to new hire orientation and the annual education program the proper use of urinary catheter dignity bags.</p> <p>4. How the corrective action(s) will be monitored to ensure the practice will not recur: The Infection Preventionist or designee, will conduct five (5) observations per week of all catheters over the next three (3) months to ensure staff are promoting and maintaining resident dignity with the use of urinary catheter dignity bags in accordance with our facility's practice guidelines and regulatory requirements. Observation reports will be reviewed by the Risk Management/Quality Assurance Committee monthly until such time consistent substantial compliance has been achieved as determined by the committee. Corrective action completion date: 4/15/19.</p>		

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

PRINTED: 04/12/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135060	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/14/2019
NAME OF PROVIDER OR SUPPLIER CARIBOU MEMORIAL LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 300 SOUTH THIRD WEST SODA SPRINGS, ID 83276		
(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 550	<p>Continued From page 3 of the brain and spinal cord) and neuromuscular (nerves and muscles) dysfunction of the bladder.</p> <p>Resident #7's care plan documented she had an indwelling catheter for neuromuscular dysfunction of the bladder.</p> <p>On 3/11/19 at 2:52 PM, Resident #7 was in her bed in her room with the door open. Her catheter drainage bag was hanging from her bed without a privacy bag. Urine was visible in the drainage bag.</p> <p>On 3/12/19 at 9:33 AM, Resident #7 was in her bed in her room with the door open. Her privacy curtain was pulled closed. Inside the privacy curtain, her catheter drainage bag was hanging from her bed without a privacy bag. Urine was visible in the drainage bag. Resident #7 said staff were to keep the drainage bag covered but they forgot sometimes.</p> <p>c. Resident #6 was readmitted to the facility on 12/8/17, with multiple diagnoses including obstructive and reflux uropathy (urine flowing back towards the kidneys) and urine retention.</p> <p>Resident #6's care plan documented she had an indwelling catheter for urine retention.</p> <p>On 3/11/19 at 2:03 PM and 4:16 PM, Resident #6 was in her recliner in her room with the door open. Her catheter drainage bag was hanging from her recliner without a privacy cover and was visible from the hallway. Urine was visible in the drainage bag.</p> <p>On 3/12/19 at 1:32 PM, Resident #6 was in her</p>	F 550			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135060	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/14/2019
NAME OF PROVIDER OR SUPPLIER CARIBOU MEMORIAL LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 300 SOUTH THIRD WEST SODA SPRINGS, ID 83276		
(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 550	<p>Continued From page 4</p> <p>recliner in her room with the door closed. Her catheter drainage bag was hanging from her recliner without a privacy cover. Resident #6 had a friend in the room with her. Urine was visible in the drainage bag.</p> <p>d. Resident #12 was admitted to the facility on 2/6/19, with multiple diagnoses including multiple sclerosis and neurogenic bladder (bladder spasms).</p> <p>Resident #12's care plan documented she had an indwelling catheter for neurogenic bladder.</p> <p>On 3/11/19 at 3:15 PM, Resident #12 was seated in her recliner in her room with the door open. Her catheter drainage bag was hanging from her dresser handle without a privacy cover. Urine was visible in the drainage bag.</p> <p>On 3/13/19 at 11:24 AM, CNA #1 said residents' catheter bags were to have a privacy bag at all times.</p> <p>On 3/13/19 at 11:37 AM, CNA #3 said residents' catheter bags were not covered with a privacy bag when they were in their rooms and were only covered when residents' left their rooms. CNA #3 said staff were told the previous day to keep the drainage bags covered at all times.</p> <p>On 3/13/19 at 2:27 PM, the CNO with the LTCD present, said she expected staff to cover the catheter drainage bags with privacy bags at all times. The LTCD said some staff knew to keep the drainage bags covered at all times and other staff were covering them only when residents were outside of their rooms.</p>	F 550			

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

PRINTED: 04/12/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135060	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/14/2019
NAME OF PROVIDER OR SUPPLIER CARIBOU MEMORIAL LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 300 SOUTH THIRD WEST SODA SPRINGS, ID 83276		
(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 578 SS=D	<p>Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v)</p> <p>§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.</p> <p>§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.</p> <p>§483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (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. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (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. (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. (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.</p>	F 578		4/15/19	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135060	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/14/2019
NAME OF PROVIDER OR SUPPLIER CARIBOU MEMORIAL LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 300 SOUTH THIRD WEST SODA SPRINGS, ID 83276		
(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 578	<p>Continued From page 6</p> <p>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 a resident's resuscitation code status was consistently and accurately documented in the medical record. This was true for 1 of 12 residents (Resident #6) whose records were reviewed for code status. This failure increased the risk of residents not having their decisions documented, honored, and respected when they were unable to make or communicate health care preferences. Findings include:</p> <p>The facility's Advanced Directives policy, dated 2/27/99, documented residents' advanced directives were to be reviewed annually or when residents' condition changed significantly and would be documented in the medical record and on the care plan.</p> <p>Resident #6 was readmitted to the facility on 12/8/17, with multiple diagnoses including hypertension (high blood pressure).</p> <p>Resident #6's Living Will and Durable Power of Attorney (DPOA), dated 9/23/16, documented her code status was do not resuscitate (DNR).</p> <p>Resident #6's POST, dated 4/30/18, documented her code status was DNR, and was signed by her DPOA.</p> <p>Resident #6's physician orders, dated 12/14/17, documented her code status was DNR.</p>	F 578	<p>F-578 Resident Rights/Advanced Directives</p> <p>1. Immediate action(s) taken for the resident(s) found to have been affected include: The code status of RI#6 was verified and entered consistently into all relevant locations within the hybrid medical record.</p> <p>2. Identification of other residents having the potential to be affected was accomplished by: Determining the code status or presence/absence of Advance Directives is required for all residents. Therefore, all residents have the potential to be affected.</p> <p>3. Actions taken/systems put into place to reduce the risk of future occurrence include: The Director of Nursing (DON) educated all staff regarding the documentation procedures for Advance Directives/code status on 3/20/2019. A chart audit of all residents was completed on 3/13/2019. Discrepant findings were addressed immediately, and all needed actions were completed on 3/13/2019.</p> <p>4. How the corrective action(s) will be monitored to ensure the practice will not recur: For a period of three (3) months, the Director of Nursing (DON) or designee will perform weekly medical record audits</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135060	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/14/2019
NAME OF PROVIDER OR SUPPLIER CARIBOU MEMORIAL LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 300 SOUTH THIRD WEST SODA SPRINGS, ID 83276		
(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 578	Continued From page 7 Resident #6's facesheet, dated 11/30/18, documented her code status was Full Code (initiate resuscitation). Resident #6's care plan documented her code status was Full Code. On 3/13/19 at 1:37 PM, RN #1 said she verified residents' code status in the following order; the Living Will, the facesheet, the electronic medical record (which matched the physician's order), and then the care plan. RN #1 said there was a difference between the Living Will, the facesheet, the electronic medical record, and the care plan. On 3/13/19 at 1:54 PM, the CNO, with the LTCD present, said the code status in Resident #6's record was unclear due to the different code status' documented in her record. The CNO and the LTCD said they expected nursing staff to follow the physician's order first regarding the resident's code status. Resident #6's medical record did not clearly document if she was to be resuscitated or wished to refuse resuscitation.	F 578	of new admissions and those residents on the MDS assessment schedule for consistent documentation of the resident's Advance Directive/code status throughout the hybrid medical record. Audit reports will be reviewed by the Risk Management/Quality Assurance Committee monthly until such time consistent substantial compliance has been achieved as determined by the committee. Corrective action completion date: 4/15/2019.		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial	F 656		4/15/19	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135060	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/14/2019
NAME OF PROVIDER OR SUPPLIER CARIBOU MEMORIAL LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 300 SOUTH THIRD WEST SODA SPRINGS, ID 83276		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 656	<p>Continued From page 8</p> <p>needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -</p> <p>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and</p> <p>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).</p> <p>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.</p> <p>(iv) In consultation with the resident and the resident's representative(s)-</p> <p>(A) The resident's goals for admission and desired outcomes.</p> <p>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.</p> <p>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, policy review, and staff interview, it was determined the facility failed to develop and implement comprehensive resident-centered care plans that included the</p>	F 656	<p>F-656 Developing Comprehensive Care Plans</p> <p>1. Immediate action(s) taken for the resident(s) found to have been affected</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135060	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/14/2019
NAME OF PROVIDER OR SUPPLIER CARIBOU MEMORIAL LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 300 SOUTH THIRD WEST SODA SPRINGS, ID 83276		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 656	<p>Continued From page 9</p> <p>residents' code status. This was true for 2 of 12 residents (#12 and #15) whose care plans were reviewed. These failures increased the residents' risk of not having their decisions honored and respected when unable to make or communicate health care preferences. Findings include:</p> <p>The facility's Comprehensive Care Plan policy, dated 2/28/18, documented a comprehensive person-centered care plan should be developed and implemented that included services to attain or maintain residents' highest practicable physical, mental, and psychological well-being, and the right to exercise rights, including the right to refuse treatment.</p> <p>a. Resident #12 was admitted to the facility on 2/6/19, with multiple diagnoses including multiple sclerosis (a potentially disabling disease of the brain and spinal cord).</p> <p>Resident #12's Living Will, dated 5/20/10, documented her code status was DNR.</p> <p>Resident #12's physician orders, dated 2/6/19, documented her code status was DNR.</p> <p>Resident #12's care plan did not include documentation of her code status.</p> <p>b. Resident #15 was admitted to the facility on 12/17/18, with multiple diagnoses including end stage renal disease.</p> <p>Resident #15's POST, dated 5/25/16, documented her code status was DNR.</p> <p>Resident #15's physician orders, dated 12/17/18,</p>	F 656	<p>include:</p> <p>Care plans of the RI#(s) 12 and 15 were reviewed and updated.</p> <p>2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected.</p> <p>3. Actions taken/systems put into place to reduce the risk of future occurrence include: All interdisciplinary care plan team members responsible for writing care plans will be re-educated 4/11/19 on the facility's policy and procedure for developing Comprehensive Care Plans.</p> <p>4. How the corrective action(s) will be monitored to ensure the practice will not recur: Care plans will be reviewed weekly in accordance with the MDS review schedule by the MDS Coordinator. All care plans will be updated as indicated. The Director of Nursing (DON), or designee, will complete weekly audits of three (3) resident's care plan for three (3) months. Random audits will be completed to ensure that comprehensive care plans, including code status, are developed for residents. Audit records will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. Corrective action completion date:</p>		

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

PRINTED: 04/12/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135060	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/14/2019
NAME OF PROVIDER OR SUPPLIER CARIBOU MEMORIAL LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 300 SOUTH THIRD WEST SODA SPRINGS, ID 83276		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 656	Continued From page 10 documented her code status was DNR. Resident #15's Living Will, dated 12/19/18, documented her code status was DNR. Resident #15's care plan did not include documentation of her code status. On 3/13/19 at 1:54 PM, the CNO said the code status was not documented in Resident #12's and Resident #15's care plans. The CNO said she expected the code status to be on the care plans.	F 656	4/15/2019		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs	F 657		4/15/19	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135060	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/14/2019
NAME OF PROVIDER OR SUPPLIER CARIBOU MEMORIAL LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 300 SOUTH THIRD WEST SODA SPRINGS, ID 83276		
(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 657	<p>Continued From page 11 or as requested by the resident.</p> <p>(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.</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 a resident's care plan was revised and updated when hospice services were discontinued. This was true for 1 of 2 residents (Resident #15) reviewed for hospice. This created the potential for harm if care and/or services were not provided appropriately due to inaccurate information in the care plan. Findings include:</p> <p>The facility's Comprehensive Care Plan policy, dated 2/28/18, documented residents' care plans were to be reviewed and revised based on residents' treatment and services.</p> <p>Resident #15 was admitted to the facility on 12/17/18, with multiple diagnoses including end stage renal disease and received hospice services.</p> <p>Resident #15's care plan, dated 1/3/19, documented she received hospice services from a local hospice agency.</p> <p>Resident #15's physician orders, dated 2/5/19, documented she was discharged from hospice services.</p> <p>On 3/13/19 at 2:14 PM, the CNO said Resident #15 was discharged from hospice services and</p>	F 657	<p>F-657 Failure to Review and Revise the Care plan After a Significant Status Change</p> <p>1. Immediate action(s) taken for the resident(s) found to have been affected include: On 3/13/2019 the MDS coordinator updated the care plan for RI# 15.</p> <p>2. Identification of other residents having the potential to be affected was accomplished by: All residents of the facility have the potential to be affected by this practice.</p> <p>3. Actions taken/systems put into place to reduce the risk of future occurrence include: The facility's Interdisciplinary Team will attend an in-service presented by the MDS Coordinator on 4/11/2019.</p> <p>4. How the corrective action(s) will be monitored to ensure the practice will not recur: Care plans will be reviewed weekly in accordance with the MDS review schedule, which include and significant status change, by the MDS Coordinator. All care plans will be updated as indicated. The Director of Nursing (DON), or designee, will complete weekly audits of</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135060	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/14/2019
NAME OF PROVIDER OR SUPPLIER CARIBOU MEMORIAL LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 300 SOUTH THIRD WEST SODA SPRINGS, ID 83276		
(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 657	Continued From page 12 her care plan should have been updated.	F 657	three (3) resident's care plan for three (3) months. Random audits will be completed to ensure that comprehensive care plans, including significant status change, are reviewed and revised for residents. Audit records will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. Corrective action completion date: 4/15/2019		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced	F 692		4/15/19	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135060	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/14/2019
NAME OF PROVIDER OR SUPPLIER CARIBOU MEMORIAL LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 300 SOUTH THIRD WEST SODA SPRINGS, ID 83276		
(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 692	<p>Continued From page 13</p> <p>by: Based on observation, record review, and staff interview, it was determined the facility failed to provide consistent assistance to maintain good nutrition. This was true for 1 of 5 residents (Resident #22) reviewed for staff assistance with Activities of Daily Living. This failure created the potential for harm if residents did not receive appropriate assistance; and experienced significant weight loss. Findings Include:</p> <p>Resident #22 was admitted to the facility on 7/26/16, with multiple diagnoses including dementia, abnormal weight loss, anorexia, and generalized anxiety disorder.</p> <p>Resident #22's Registered Dietician's (RD) weight review and physician notification form, dated 2/22/19, documented an eight-pound weight loss in a 6-week period. The resident's weight declined from 142 to 134 pounds. The physician documented due to Resident #22's dementia, weight loss was to be expected. The physician directed staff to continue to monitor her weight and if she lost more weight, then the physician was to be notified for further interventions.</p> <p>Resident #22's care plan, with a review date of 2/22/19, documented she was at risk for weight loss due to dementia and directed staff to cue and assist her with meals.</p> <p>On 3/11/19 at 5:30 PM, twelve residents were in the main dining room and five staff members served trays and set up the residents' meals. Five of the residents required feeding assistance. At 5:45 PM, Resident #22's dinner meal was set</p>	F 692	<p>F – 692 Nutrition/Hydration Status Maintenance</p> <p>1. Immediate Action(s) taken for the resident found to have been affected include:</p> <p>The Registered Dietitian had assessed and noted weight loss of R1#22 on 3/7/19. Revisions were made to the care plan and revised interventions were reviewed with staff involved in the care of each resident. The staff involved were immediately in-serviced on the proper procedures for maintaining resident dignity during mealtimes.</p> <p>2. Identification of other residents having the potential to be affected was accomplished by:</p> <p>The facility has determined that all residents have the potential to be affected.</p> <p>3. Actions taken/systems put into place to reduce the risk of future occurrence include:</p> <p>An in-service education program was conducted by the Director of Nursing Services on 3/20/2019 with all direct care staff addressing nutritional interventions including weight documentation and monitoring. Facility personnel involved in providing feeding assistance to residents have</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135060	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/14/2019
NAME OF PROVIDER OR SUPPLIER CARIBOU MEMORIAL LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 300 SOUTH THIRD WEST SODA SPRINGS, ID 83276		
(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 692	<p>Continued From page 14</p> <p>up for her and was left uncovered. From 5:45 PM to 6:10 PM, she sat in her wheelchair and rolled back and forth from the table and was not assisted or cued by staff to eat. At 6:10 PM, a staff member began assisting her with her meal.</p> <p>On 3/12/19 at 8:10 AM, Resident #22 was in the main dining room at the table with her breakfast meal uncovered. From 8:10 AM to 8:30 AM, she sat in her wheelchair and was not assisted or cued by staff to eat. At 8:30 AM, a staff member began assisting her with her meal.</p> <p>On 3/15/19 at 9:24 AM, Resident #22 was in the main dining room at the table with her breakfast meal uncovered. CNA #1 and CNA #2 were assisting two other residents at the table. Resident #22 was not assisted or cued by staff to eat. CNA #1 and CNA #2 said Resident #22's food had been on the table for about 10 minutes. They said if the meal sat for an hour, it was re-heated or replaced with an alternate meal.</p> <p>On 3/12/19 at 10:25 AM, the Certified Dietary Manager (CDM) said it was very difficult to get Resident #22 to eat. The CDM stated her prescribed diet was mechanical soft with high protein, high calories, and fat. She said the facility added a candy bar to her snacks, she was getting shakes every day, as well as Ensure (a dietary supplement) if she did not eat at least 25% of her meal. The CDM said the RD was following her closely.</p> <p>On 3/14/19 at 10:05 AM, the LTCD said Resident #22 required staff assistance to eat and staff should have helped her to eat. The LTCD said Resident #22's meals should have been covered</p>	F 692	<p>been in-serviced on the proper procedures for assisting residents with meals to ensure resident dignity is maintained during mealtimes. A "Validation Checklist" was completed for each individual whose duties involve feeding assistance to determine if he/she was performing the procedure correctly. Findings were reviewed with each individual and corrective action was provided as needed.</p> <p>4. How the corrective action(s) will be monitored to ensure the practice will not recur: The interdisciplinary team will review each weight report to ensure appropriate measurements are recorded and complete and to monitor weight fluctuations. The Director of Nursing (DON), or designee, will complete six (6) weekly chart audits for three (3) months to ensure that weight changes are identified and appropriate interventions have been put in place. Care plans will be reviewed for updated information to reflect these interventions. The Director of Nursing (DON), or designee, will conduct six (6) random observations per week of staff during mealtimes over the next three (3) months to ensure staff are promoting and maintaining resident dignity during mealtimes in accordance with our facility's practice guidelines and regulatory requirements. Audited records will be reviewed by the Risk Management/Quality Assurance</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135060	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/14/2019
NAME OF PROVIDER OR SUPPLIER CARIBOU MEMORIAL LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 300 SOUTH THIRD WEST SODA SPRINGS, ID 83276		
(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 692	Continued From page 15 until staff assisted her. She said residents' meals were be re-heated as needed or within an hour if the meals were not eaten by that time.	F 692	Committee until such time consistent substantial compliance has been achieved as determined by the committee.		
F 880 SS=D	The facility failed to provided assistance and cueing to Resident #22 had experienced a 5.6% unplanned weight loss in a 6 week period. Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §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	F 880	Corrective action completion date: 4/15/2019	4/15/19	

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

PRINTED: 04/12/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135060	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/14/2019
NAME OF PROVIDER OR SUPPLIER CARIBOU MEMORIAL LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 300 SOUTH THIRD WEST SODA SPRINGS, ID 83276		
(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 16</p> <p>possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and</p> <p>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced</p>	F 880			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135060	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/14/2019
NAME OF PROVIDER OR SUPPLIER CARIBOU MEMORIAL LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 300 SOUTH THIRD WEST SODA SPRINGS, ID 83276		
(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 17</p> <p>by: Based on observation, record review, policy review, and staff interview, it was determined the facility failed to ensure urinary catheter bags were not placed on garbage cans. This was true for 1 of 4 residents (Resident #15) who were reviewed for urinary catheter use. This deficient practice placed residents at risk of infection. Findings include:</p> <p>The facility's catheter infection control policy, dated 9/28/17, documented to ensure adherence to hand hygiene and proper care of catheters.</p> <p>Resident #15 was admitted to the facility on 12/17/18, with multiple diagnoses including end stage renal disease.</p> <p>Resident #15's physician orders, dated 2/4/19, documented an indwelling catheter.</p> <p>Resident #15's care plan documented she had an indwelling catheter for end stage renal disease.</p> <p>On 3/11/19 at 3:50 PM, 4:25 PM, and 5:59 PM and on 3/12/19 at 1:19 PM, Resident #15 was in her recliner in her room. Her catheter bag was hanging with a hook, from her plastic garbage can. The drainage bag was in direct contact with the garbage can and the garbage can liner.</p> <p>On 3/13/19 at 11:37 AM, CNA #3 said residents' catheter drainage bags were sometimes hung on their trash cans.</p> <p>On 3/13/19 at 2:31 PM, the CNO said Resident #15's catheter bag should not to be hung on her</p>	F 880	<p>F-880 Infection Prevention and Control</p> <p>1. Immediate action(s) taken for the resident(s) found to have been affected include: Urinary catheter bag of R# 15 was immediately removed from hanging on the garbage can. The staff involved were immediately in-serviced on the proper procedures for placement of urinary catheter bags in relation to infection control measures.</p> <p>2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents who have urinary catheters have the potential to be affected.</p> <p>3. Actions taken/systems put into place to reduce the risk of future occurrence include: An in-service education program was conducted by the Infection Preventionist on 3/20/2019 with all direct care staff addressing placement of urinary catheter bags as related to infection prevention. Infection Preventionist will included, to new hire orientation and the annual education program, the proper placement of urinary catheter bags.</p> <p>4. How the corrective action(s) will be monitored to ensure the practice will not recur: The Infection Preventionist or designee, will conduct five (5) observations per week of all catheters over the next three (3) months to ensure staff are promoting</p>		

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

PRINTED: 04/12/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135060	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/14/2019
NAME OF PROVIDER OR SUPPLIER CARIBOU MEMORIAL LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 300 SOUTH THIRD WEST SODA SPRINGS, ID 83276		
(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 18 trash can. She said she expected staff to hang drainage bags on the side of a chair or on the side of the bed. On 3/14/19 at 10:35 AM, the Infection Control Nurse said catheter bags were not to be hung on trash cans because of possible infections. She said placing catheter bags on a trash can was similar to placing them on the floor, which was not appropriate.	F 880	and maintaining infection prevention with the use of urinary catheter bags in accordance with our facility's practice guidelines and regulatory requirements. Observation reports will be reviewed by the Risk Management/Quality Assurance Committee monthly until such time consistent substantial compliance has been achieved as determined by the committee. Corrective action completion date: 4/15/19.		