



IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE- Governor
DAVE JEPPESEN- Director

TAMARA PRISOCK—ADMINISTRATOR
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BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
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July 5, 2019

Jory Hunter, Administrator
Bear Lake Memorial Skilled Nursing Facility
164 South Fifth Street
Montpelier, ID 83254-1557

Provider #: 135070

Dear Mr. Hunter:

On **June 20, 2019**, a survey was conducted at Bear Lake Memorial Skilled Nursing Facility 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 an isolated deficiency that constitutes actual 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.) **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 **July 15, 2019**. Failure to submit an acceptable PoC by **July 15, 2019**, may result in the imposition of civil monetary penalties by **August 7, 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*.

This agency is required to notify CMS Region X of the results of this survey. We are recommending that CMS impose the following remedy(ies):

- **Civil money penalty**
- **Denial of payment for new admissions effective September 20, 2019**

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **December 20, 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.

Jory Hunter, Administrator
July 5, 2019
Page 3 of 3

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

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/ta/bid/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 **July 15, 2019**. If your request for informal dispute resolution is received after **July 15, 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, 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: 07/19/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135070	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/20/2019
NAME OF PROVIDER OR SUPPLIER BEAR LAKE MEMORIAL SKILLED NURSING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 164 SOUTH FIFTH STREET MONTPELIER, ID 83254		
(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 June 16, 2019 through June 20, 2019. The surveyors conducting the survey were: Edith Cecil, RN, Team Coordinator Presie Billington, RN Survey Abbreviations: ADLs = Activities of Daily Living cm = centimeter CNA = Certified Nursing Assistant DNS = Director of Nursing Services LPN = Licensed Practical Nurse LSW = Licensed Social Worker MAR = Medication Administration Record MDS = Minimum Data Set assessment mg = milligrams mm = millimeter RN = Registered Nurse	F 000			
F 568 SS=D	Accounting and Records of Personal Funds CFR(s): 483.10(f)(10)(iii) §483.10(f)(10)(iii) Accounting and Records. (A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. (B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. (C)The individual financial record must be	F 568		7/31/19	

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

TITLE

(X6) DATE

Electronically Signed

07/15/2019

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.

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F 568	<p>Continued From page 1 available to the resident through quarterly statements and upon request. This REQUIREMENT is not met as evidenced by:</p> <p>Based on resident representative and staff interview, policy review, and record review, it was determined the facility failed to provide a financial record, or quarterly statement, to 2 of 2 residents (#3 and #28) whose personal fund accounts were reviewed. This failure created the potential for harm if concerns, including inaccuracies, about the personal fund accounts were not addressed. Findings include:</p> <p>The facility's policy, Deposit of Resident Funds, dated 4/2017, documented the resident is provided a confidential quarterly statement of funds on deposit with the facility, including the activity since the previous statement.</p> <p>a. Resident #3 was admitted to the facility on 6/24/13, with diagnoses that included legal blindness and chronic pain.</p> <p>On 6/17/19, at 10:06 AM, Resident #3's representative stated she received a financial statement "about once a year."</p> <p>b. Resident #28 admitted to the facility on 1/25/19, with diagnoses that included dementia, anxiety, and depression.</p> <p>On 6/17/19, at 11:16 AM, Resident #28's representative, her daughter, stated she had received receipts but she had not received a financial statement.</p> <p>On 6/18/19, at 11:55 AM, the LSW stated she</p>	F 568	<p>F568</p> <ol style="list-style-type: none"> 1. For resident #3 and #28: statements were hand delivered or sent to be mailed to resident or representative on 6/18/2019. 2. Any resident who maintains a personal fund account at the facility has the potential to be affected by this alleged deficient practice. Statements were printed and hand delivered or sent to be mailed to all residents/representatives with an account on 6/18/2019. 3. Systemic changes will be made to ensure all residents will receive a quarterly statement of their personal fund account along with the receipts that were being sent previously. Statements for personal fund accounts will be provided quarterly to the resident or their representative. 4. Social Services or designee will audit all personal fund accounts to ensure a statement has been sent quarterly x1 and will report findings to the QAPI committee for further recommendation. 		

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F 568	Continued From page 2 sent receipts and statements out quarterly, but "mostly I have just sent out receipts."	F 568			
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.	F 582		7/31/19	

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F 582	<p>Continued From page 3</p> <p>(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.</p> <p>(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.</p> <p>(v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, review of billing records, and staff interview, it was determined the facility failed to ensure residents were provided advance notice of the reason their Medicare Coverage A was being terminated during their stay in the SNF and how to appeal the termination process. This deficient practice was true for 2 of 3 residents (#2 & #19) reviewed for notice of Medicare non-coverage (NOMNC). This failure created the potential for residents to experience financial distress and psychological harm when residents were not informed of how to appeal the ending of their Medicare coverage. Findings include:</p> <p>a. Resident #2 admitted to the facility on 2/22/19, with multiple diagnoses which included a right femur (thighbone) fracture.</p>	F 582	<p>F582</p> <p>1. Resident #2 POA/representative was notified of Medicare non-coverage beginning 3/2/2019 and right to appeal on 2/26/2019, POA/representative denied wanting to appeal the decision however the ABN form was signed instead of the NOMNC. Resident #19 and representative were notified of Medicare non-coverage beginning 3/11/2019 and their right to appeal on 3/8/2019, they denied wanting to appeal the decision however the ABN form was signed instead of the NOMNC.</p> <p>2. Any resident who was receiving Medicare covered services has the potential to be affected by this alleged deficient practice. Records were reviewed and found that all</p>		

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F 582	Continued From page 4 A Physical Therapy Daily Treatment Note, dated 3/1/19, documented Resident #2 was discharged from skilled therapy services on 3/1/19. The facility's billing records documented Resident #2's insurance coverage changed from Medicare Coverage A to another payor source on 3/2/19. A NOMNC was not found in Resident #2's record. b. Resident #19 was admitted to the facility on 1/7/19, with multiple diagnoses which included muscle weakness. A Physical Therapy Daily Treatment Note, dated 3/11/19, documented Resident #19 was discharged from skilled therapy services on 3/10/19. The facility's billing records documented Resident #19's insurance coverage changed from Medicare Coverage A to another payor source on 3/11/19. A NOMNC was not found in Resident #19's record. On 6/19/19, at 9:42 AM, the LSW stated the facility did not provide NOMNCs to residents.	F 582	residents/representatives were notified of their Medicare coverage ending and their right to appeal. 3. Social Services reviewed the requirements at F582, the NOMNC form will be utilized in accordance with the requirements. 4. Social Services or designee will audit records of residents receiving Medicare benefits to ensure correct forms are being utilized at time of non-coverage weekly x4 then monthly x2 and will report findings to the QAPI committee for further recommendation.		
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	F 656		7/31/19	

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F 656	<p>Continued From page 5</p> <p>objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial 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: Based on record review, policy review, observation, and staff interview, it was</p>	F 656	<p>F656</p> <p>1. Resident #1 care plan was updated</p>		

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F 656	<p>Continued From page 6</p> <p>determined the facility failed to ensure comprehensive care plans were developed and implemented to address the diabetic and range of motion needs of residents. This was true for 2 of 12 residents (#1 and #33) whose care plans were reviewed. These deficient practices created the potential for the residents to receive inappropriate or inadequate care with subsequent decline in health. Findings include:</p> <p>The facility's policy Care Plans, Comprehensive Person-Centered, revised December 2016, documented the following:</p> <p>*The Interdisciplinary Team (IDT), in conjunction with the resident and his/her family or legal representative, developed and implemented a comprehensive, person-centered care plan for each resident.</p> <p>*The care plan interventions were derived from a thorough analysis of the information gathered as part of the comprehensive assessment.</p> <p>*Incorporated identified problem areas.</p> <p>*Incorporated risk factors associated with identified problems.</p> <p>1. Resident #1 was admitted to the facility on 8/7/13, with multiple diagnoses which included polyosteoarthritis and hemiplegia (paralysis of one side of the body).</p> <p>A quarterly MDS assessment, dated 6/3/19, documented he had moderate cognitive impairment.</p>	F 656	<p>on 6/18/2019 to reflect resident's preferences for use of stuffed animal. Resident #33 care plan was updated on 6/19/2019 to include diagnosis of and treatment for diabetes. CNA's, RNA and nurses were educated on the updated care planned approaches for these residents.</p> <p>2. All residents have the potential to be affected by this alleged deficient practice.</p> <p>3. All nurses will receive education on how to update care plans to include specific diagnosis and range of motion/devices on or before 7/31/2019.</p> <p>4. DON or designee will audit care plans to ensure any new diagnosis or ROM/Device have been care planned weekly x4, then monthly x2 and will report findings to the QAPI committee for further recommendation.</p>		

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F 656	<p>Continued From page 7</p> <p>A care plan, revised on 3/25/18, documented Resident #1 had limited physical mobility related to hemiplegia and staff were directed to place a stuffed animal in his left arm to help maintain range of motion in his left arm.</p> <p>On 6/16/19 at 12:48 PM, Resident #1 was observed in bed with his left arm flexed to his chest. Resident #1 did not have a stuffed animal in his left arm.</p> <p>On 6/17/19 at 11:22 AM, Resident #1 was observed with his family representative in the Activity Room. Resident #1's left arm was flexed to his chest and he did not have a stuffed animal in his left arm.</p> <p>On 6/17/19 at 3:38 PM, Resident #1 was observed sleeping in his bed with both arms flexed to his chest. Resident #1 did not have a stuffed animal in his left arm.</p> <p>On 6/18/19 at 9:07 AM, the DNS said Resident #1 was not required to have the stuffed animal between his left arm and chest 24 hours a day. When asked how long Resident #1 should keep the stuffed animal between his left arm and chest to maintain his range of motion, the DNS said she would review Resident #1's record and get back to the surveyor.</p> <p>On 6/18/19 at 2:34 PM, the Administrator, together with the DNS, said Resident #1's stuffed animal was provided to him for emotional support and range of motion. The Administrator said Resident #1 had a history of refusing to use the stuffed animal. The Administrator said if Resident #1 wanted the stuffed animal to be place</p>	F 656			

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F 656	Continued From page 8 between his left arm and his chest he could request the stuffed animal from staff. Resident #1's care plan did not describe how often and how long he was to be provided with a stuffed animal to maintain the range of motion in his left arm. 2. Resident #33 was admitted to the facility on 8/5/16, with multiple diagnoses which included diabetes mellitus. A quarterly MDS assessment, dated 5/12/19, documented she had severe cognitive impairment and diabetes mellitus and received insulin injections during the last seven days. Resident #33's diagnosis of diabetes mellitus was not addressed in her care plan. On 6/19/19 at 3:46 PM, the DNS said Resident #33 should have a diabetic care plan.	F 656			
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.	F 657		7/31/19	

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F 657	<p>Continued From page 9</p> <p>(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.</p> <p>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs 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 observation, record review, and staff interview, it was determined the facility failed to ensure residents' care plans were revised as care needs changed. This was true for 2 of 12 residents (#3 and #13) reviewed for care plan revision. This failure had the potential for the residents to receive inappropriate or inadequate care with subsequent decline in health. Findings include:</p> <p>1. Resident #3 was admitted to the facility on 6/24/13, with diagnoses that included legal blindness and chronic pain.</p> <p>The annual MDS assessment, dated 3/6/19, documented Resident #3 was moderately cognitively impaired and required extensive assistance with two staff members for bed mobility, dressing, toileting, and personal hygiene. Resident #3 required limited assistance for eating and was dependent on two staff members for transfers. The MDS documented</p>	F 657	<p>F657</p> <ol style="list-style-type: none"> 1. Resident #3 care plan was updated after physician's visit on 7/11/2019 to include the stage IV pressure ulcer and treatment. Resident #13 care plan was updated on 6/20/2019 to include the skin impairment and treatment. 2. All residents have the potential to be affected by this alleged deficient practice. 3. All nurses will receive education on the need to update the care plan with any new skin alteration on or before 7/31/2019. 4. DON or designee will audit skin checks and wound documentation to identify new skin alterations and will audit care plan to ensure appropriate updates have been made weekly x4, then monthly x2 and will report findings to the QAPI committee for further recommendation. 		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135070	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/20/2019
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F 657	<p>Continued From page 10</p> <p>Resident #3 was at risk for pressure ulcers and had one Stage II pressure ulcer (partial thickness skin loss with exposed dermis [tissue below surface of the skin], which presents as an abrasion, blister, or shallow crater.)</p> <p>A Wound Assessment, dated 8/16/18 at 11:21 AM, documented Resident #3 had developed a Kennedy ulcer (ulcer that develops when death is imminent) over her sacral/buttock area.</p> <p>A Wound Assessment, dated 6/7/19 at 12:37 PM, documented Resident #3 had acquired in-house Kennedy pressure ulcer that presented as a Stage IV pressure ulcer (full thickness tissue loss with exposed bone, tendon, or muscle).</p> <p>The care plan, dated 3/10/18, and revised on 6/7/19, documented Resident #3 was at risk for skin alterations related to poor arterial perfusion and history of pressure ulcers. The Stage IV pressure ulcer was not addressed in the care plan.</p> <p>On 6/19/19 at 5:00 PM, the DNS stated the pressure ulcer was not addressed on Resident #3's care plan.</p> <p>2. Resident #13 was admitted to the facility on 3/26/19, with multiple diagnoses which included dementia and generalized muscle weakness.</p> <p>On 6/16/19, at 3:30 PM, Resident #13 was sitting in his wheelchair near the nursing station. A dressing was observed to the back of his left leg above the heel.</p> <p>A progress note, dated 6/10/19, documented a</p>	F 657			

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F 657	Continued From page 11 new skin alteration to the back of Resident #13's left lower leg. The note did not document the cause of the skin impairment or a plan to prevent reoccurrence. On 6/20/19 at 11:14 AM, RN #1 stated Resident #13 scraped his leg on his wheelchair and she had documented it. Resident #13's care plan did not address the injury to his left leg. On 6/19/19 at 5:00 PM, the DNS stated staff should update care plans when anything changes with the residents and Resident #13's skin impairment was not addressed in his care plan.	F 657			
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure bowel care interventions were developed and implemented for 3 of 3 residents (#14, #15, and #17) reviewed for bowel care. This deficient practice placed residents at risk of harm related to complications from constipation or impaction.	F 684	F684 1. Resident #14 had a BM on 6/14/2019. Resident #14 was assessed on 7/15/2019 and shows no signs or symptoms of injury or adverse effects from not having a BM within 3 days. Resident #17 had a BM on 5/31/2019. Resident #17 was assessed	7/31/19	

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F 684	<p>Continued From page 12</p> <p>Findings include:</p> <p>a. Resident #14 was admitted to the facility on 11/6/18, with multiple diagnoses including cirrhosis of the liver.</p> <p>A significant change MDS assessment, dated 3/29/19, documented Resident #14 had moderate cognitive impairment, required extensive two person assistance for toileting, and was continent of bowel.</p> <p>Resident #14's June 2019 physician's orders included:</p> <p>*Milk of Magnesia (MOM) 473 ml bottle, give 30 ml by mouth QID (four times a day) as needed for constipation ordered on 2/1/19.</p> <p>Resident #14's Bowel Movement Records, dated 5/21/19 through 6/19/19, documented he did not have a bowel movement between:</p> <p>*5/24/19 and 5/27/19 (4 days) *6/9/19 and 6/13/19 (5 days)</p> <p>Resident #14's MAR, dated 5/1/19 through 6/18/19, documented he received MOM on 6/12/19 with no results. There was no documentation Resident #14 was offered or received MOM on 6/13/19. Additional bowel care interventions were not documented.</p> <p>b. Resident #17 was admitted to the facility on 6/28/17, with multiple diagnoses which included unspecified dementia without behavioral disturbances.</p>	F 684	<p>on 7/15/2019 and shows no signs or symptoms of injury or adverse effects from not having a BM within 3 days. Resident #15 had a BM on 6/16/2019. Resident #15 was assessed on 7/15/2019 and shows no signs or symptoms of injury or adverse effects from not having a BM within 3 days.</p> <p>2. All residents have the potential to be affected by this alleged deficient practice.</p> <p>3. All nurses received education on how to monitor BM frequency and the necessity of following physician orders for bowel management on or before 7/31/2019.</p> <p>4. DON or designee will audit BM frequency and MAR documentation for administration of ordered PRN bowel management medications daily x5, then weekly x3, then monthly x2 and will report findings to the QAPI committee for further recommendation.</p>		

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F 684	<p>Continued From page 13</p> <p>A quarterly MDS assessment, dated 4/7/19, documented Resident #17 had severe cognitive impairment, required extensive one person assistance for toileting, and was continent of bowel.</p> <p>Resident #17's June 2019 physician's orders included:</p> <p>*MOM 473 ml bottle, give 30 ml by mouth once daily as needed for constipation ordered on 2/1/19.</p> <p>*Docusate sodium 100 mg, give one capsule by mouth two times a day for constipation, ordered on 2/1/19.</p> <p>Resident #17's Bowel Movement Records, dated 5/21/19 through 6/19/19, documented she did not have a bowel movement between 5/26/19 and 5/30/19 (5 days).</p> <p>Resident #17's MAR, dated 5/1/19 through 6/19/19, documented she received MOM on 5/31/19. Medication to treat Resident #17's constipation was provided on day 6 of no bowel movement.</p> <p>c. Resident #15 was admitted to the facility on 11/5/10, with multiple diagnoses which included dementia, macular degeneration, and constipation.</p> <p>A quarterly MDS assessment, dated 4/5/19, documented Resident #15 was moderately cognitively impaired, required extensive assistance of 2 people for toileting, and was always continent of bowel.</p>	F 684			

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F 684	Continued From page 14 Resident #15's physician orders, dated 2/1/19, directed staff to provide Senna Gen 8.6 mg, one tablet 2 times a day for the diagnosis of constipation. The May 2019 Bowel Movement Records documented Resident #15 did not have a bowel movement from 5/21/19 through 5/27/19 (6 days). Resident #15's MAR, from 5/1/19 to 5/30/19, did not include documentation that additional bowel care medications were requested from the physician or provided to Resident #15. The June Bowel Movement Records documented Resident #15 did not have a bowel movement from 6/5/19 through 6/8/19 (4 days) or from 6/12/19 through 6/15/19 (4 days). A physician's order was obtained on 6/16/19, directing staff to provide MOM 30 mls once daily if needed for constipation. Resident #15's MARs, from 6/1/19 to 6/20/19, documented MOM 30 mls was provided on 6/16/19. On 6/18/19 at 1:52 PM, LPN #1 said the facility's bowel protocol directed the staff to give MOM if a resident did not have a bowel movement for three days, and to give a suppository if no response with MOM. On 6/18/19 at 1:55 PM, the DNS said the facility did not have a bowel protocol. The DNS said if a resident did not have a bowel movement in 3	F 684			

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F 684	Continued From page 15 days the nurse should give the resident prune juice, and if no response with prune juice the nurse should give the resident MOM.	F 684			
F 686 SS=G	The facility failed to ensure residents were provided bowel care to address constipation and that staff were aware procedures to follow for residents' constipation. Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, policy review, staff interview, and record review, it was determined the facility failed to prevent the development of avoidable pressure ulcers. This was true for 2 of 2 residents (#3 and #28) reviewed for pressure ulcers. Resident #3 was harmed when she developed a suspected deep tissue injury that worsened to a Stage IV (full thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage, or bone in the ulcer) pressure ulcer to her sacrum	F 686	F686 1. Resident #3: RN wound care assessment will be updated to ensure consistent & thorough documentation on wound measurements. Physician & RN wound nurse assessed resident #3 wound on 7/11/2019, physician and RN will continue to monitor & assess wound routinely. A wound vac was placed on resident #3 pressure ulcer on 6/25/2019. Resident #3 care plan has been updated	7/31/19	

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F 686	<p>Continued From page 16 (bottom of the spine). Resident #28 was harmed when she developed an unstageable pressure ulcer to her sacrum and suspected deep tissue injuries to her right heel and left calf. Findings include:</p> <p>The facility's policy for Pressure Ulcer Assessment Guidelines, dated 9/5/17, documented:</p> <p>*To ensure a resident who entered the facility without pressure ulcers did not develop pressure ulcers unless the resident's clinical condition demonstrated they were unavoidable; and a resident having pressure ulcers received necessary treatment and services that promoted healing and prevented new ulcers from developing.</p> <p>*All new developing pressure ulcers must be measured and graded according to acceptable definitions of pressure ulcers.</p> <p>The website www.healthline.com, dated 6/15/18, documented, "A Kennedy ulcer, also known as a Kennedy terminal ulcer (KTU), is a dark sore that develops rapidly during the final stages of a person's life. Kennedy ulcers grow as skin breaks down as part of the dying process." The National Pressure Ulcer Advisory Panel, dated March 2017, described a Kennedy pressure ulcer as pear shaped, always on the coccyx or sacrum, red, yellow, and black, sudden onset, and death is imminent.</p> <p>1. Resident #3 was admitted to the facility on 6/24/13, with diagnoses that included legal blindness and chronic pain.</p>	F 686	<p>to reflect treatments and interventions for and status of the pressure ulcer.</p> <p>Resident # 28: RN wound care assessment will be updated to ensure consistent & thorough documentation on wound measurements. Physician & RN wound nurse assessed resident #28 wounds on 7/11/2019, physician and RN will continue to monitor & assess wounds routinely. A wound vac was placed on resident #28 sacral pressure ulcer on 7/15/2019. Resident #28 care plan has been updated to reflect treatments and interventions for and status of the pressure ulcers. Facility will implement a protocol for skin checks to be done when residents have a removable device ordered.</p> <p>2. All residents have the potential to be affected by this alleged deficient practice.</p> <p>3. The wound care nurse will receive additional education on pressure ulcer staging, Kennedy pressure ulcers, and the importance of requesting order changes for new treatments if a wound is not healing as anticipated on or before 7/31/2019. Physicians to be educated that wounds should be addressed on physician visit notes on or before 7/31/2019. All nurses to be educated that orders should be obtained to check under braces or devices daily for skin breakdown on or before 7/31/2019. All nurses to receive education on pressure ulcer prevention on or before 7/31/2019.</p> <p>4. DON or designee will audit to ensure daily skin checks are in place for under any braces or devices daily x5, then</p>		

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F 686	Continued From page 17 The annual Minimum Data Set (MDS) assessment, dated 3/6/19, documented Resident #3 was moderately cognitively impaired and required extensive assistance with two staff members for bed mobility, dressing, toileting, and personal hygiene. Resident #3 required limited assistance for eating and was dependent on two staff members for transfers. The MDS assessment documented Resident #3 was at risk for pressure ulcers and had one Stage II (Partial-thickness loss of skin with exposed dermis, presenting a shallow open ulcer) pressure ulcer. A Wound Assessment, dated 8/16/18 at 11:21 AM, documented Resident #3 had an in-house acquired Kennedy pressure ulcer over the sacral/buttock area. The assessment documented the sacral/buttock area did not have drainage, odor, and no tunneling or undermining. The surrounding tissue was normal. The weekly wound summary documented, "large purple/maroon area, very slow to blanch, open area still noted to the center of the gluteal fold and measurements are unchanged from last assessment..." The treatment was for staff to apply, "copious amounts of vaseline" several times a day. The assessment did not include measurements of the wound or when the pressure ulcer was first identified. A Wound Assessment, dated 10/26/18 at 12:32 PM, documented Resident #3 had an in-house acquired Kennedy pressure ulcer with an open area in the center above the gluteal fold (where the top of the thigh meets the buttock). The wound edges were defined and flushed, the	F 686	weekly x3, then monthly x2 and will report findings to the QAPI committee for further recommendation. DON or designee will audit the healing status of all wounds and accompanying treatments weekly x4, then monthly x2 and will report findings to the QAPI committee for further recommendation.		

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F 686	<p>Continued From page 18</p> <p>wound bed was pink and white, no tunneling or undermining, and with minimal clear drainage. The surrounding skin tissue was red. Pressure ulcers are measure by length, width, and depth, in that order. The assessment documented "The ulcer in the center of the wound has now divided in half with new epithelial growth the left side measures 1 cm x 0.5 cm x 2 mm, and the right side measures 3 cm x 1 cm x 2 mm." The additional comments documented, "Overall appearance of this areas looks to be a Kennedy (ulcer) as the area about 11 cm x 10 cm is maroon in color, does blanch with open ulcer in the center of the proximal gluteal fold, there is sloughing noted on the right buttock that is very superficial and dry..." The assessment documented the wound status had "improved." The wound care treatment was for staff to apply Medifil paste (wound healing treatment) in the wound bed and cover with an adhesive dressing.</p> <p>A Wound Assessment, dated 12/11/18 at 2:15 PM, documented Resident #3 had acquired an in-house Kennedy pressure ulcer to her sacrum/buttocks, and the entire reddened area measured 9 cm x 10 cm. Another wound measurement documented on the assessment was 26 x 3 x 2. The measurement did not include how the wound was measured, in centimeters or millimeters. The assessment documented the wound edges were defined and flushed, the wound bed was beefy red, and no tunneling or undermining. There was no drainage or odor and the surrounding skin tissue was normal. The assessment documented the wound continued to improve each week. The additional comments documented the small pressure ulcer to the left was closed, "leaving only the ulcer on the right</p>	F 686			

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F 686	<p>Continued From page 19</p> <p>after the one ulcer divided about 2 months ago." The wound care treatment was for staff to apply Medifil paste in the wound bed and cover with an adhesive dressing.</p> <p>A Wound Assessment, dated 2/26/19 at 10:24 AM, documented Resident #3 had an in-house acquired Kennedy pressure ulcer to her sacrum. The measurements were documented 17 x 8 x 5. The measurements did not include how the wounds were measured, in centimeters or millimeters, and did not specify if the measurement was that of the entire reddened area or the open ulcer. The assessment documented the wound edges were defined and the wound bed was pale pink with minimal clear drainage, no tunneling or undermining, and the surrounding skin tissue was normal. The additional comments documented to continue with the treatment for staff to apply Medifil paste in the wound bed and cover with an adhesive dressing.</p> <p>A Physician's order, dated 3/26/19, directed the application of Medifil paste to the right lateral lip of Resident #3's wound bed, to pack the deeper center of the ulcer with sterile gauze lightly soaked in normal saline and covered with Medifil, and to change the dressing every Tuesday, Friday, and as needed.</p> <p>A Physician Visit Note, dated 5/2/19, documented Resident #3 was thin and had a "stable sacral wound."</p> <p>A Wound Assessment, dated 5/3/19 at 11:59 AM, documented Resident #3 had an in-house acquired Kennedy pressure ulcer to her sacrum.</p>	F 686			

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F 686	<p>Continued From page 20</p> <p>The wound measurements were 18 x 18 x 5. The measurements did not include how the wounds were measured, in centimeters or millimeters. The assessment documented the wound edges were defined and jagged and the wound bed was pale pink and had about 2 mm of undermining (destruction of tissue or ulceration extending under the skin edges) around entire ulcer, with minimal red drainage, and the surrounding skin tissue was red. The assessment documented the surrounding tissue was 10 cm x 10 cm with red area around the ulcer. The assessment documented the wound status was unchanged.</p> <p>A Wound Assessment, dated 6/7/19 at 12:37 PM, documented Resident #3 had an in-house acquired Kennedy pressure ulcer that presented as a Stage IV pressure ulcer. The wound measurements were 25 x 15 x 10. The measurements did not include how the wounds were measured, in centimeters or millimeters, or indicate if the measurements related to the entire reddened area or the open ulcer. The assessment documented the wound edges were defined and the wound bed was beefy red, no tunneling or undermining with a moderate amount of clear and red drainage. The surrounding skin tissue was red. The assessment documented the wound status was unchanged and to continue with the same wound care treatment of Medifil paste and cover the wound with an adhesive dressing.</p> <p>Resident #3's Risk for Skin Alterations Related to History of Pressure Ulcers Care Plan, dated 3/10/18 and revised on 6/7/19, documented a decline in skin condition was anticipated related to her failure to thrive and interventions would be</p>	F 686			

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NAME OF PROVIDER OR SUPPLIER BEAR LAKE MEMORIAL SKILLED NURSING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 164 SOUTH FIFTH STREET MONTPELIER, ID 83254		
(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 686	<p>Continued From page 21</p> <p>in place to help maintain her comfort. The care plan did not identify a current pressure ulcer. The interventions on the care plan directed staff to reposition Resident #3 every 30 minutes during the day and evening, to use an air overlay on the bed, and a pressure relieving mattress. Resident #3's care plan also directed a scoop mattress (mattress with heightened or beveled edges) be placed over the mattress air overlay to keep the air overlay centered and to keep it from sliding off the bed. RN #2 stated a scoop mattress was not in place. An air overlay was in place which she stated had been utilized for residents for 10 years.</p> <p>A Physician Visit Note, dated 6/6/19, documented Resident #3 was well-nourished. The pressure ulcer was not addressed in the note. At 11:00 AM on 6/18/19, the Administrator provided the Physician Visit Note, dated 6/6/19, with the following addendum: "Pt's (Patient's) nutritional status fluctuates but is generally poor. Staff, including dietician, have exhausted avenues to improve beyond current situation. Pt declines aggressive measures. This in turn will affect the ability for pressure ulcer to heal. It is anticipated that it won't heal but will try to keep it stable. Well-nourished was still checked on the assessment.</p> <p>On 6/17/19 at 10:30 AM, Resident #3 permitted LPN #1 to look at her mattress. An air-overlay mattress was over a pressure relieving mattress. A scoop mattress was not on the bed.</p> <p>On 6/19/19 at 5:00 PM, the DNS stated the wound/skin nurse, RN #2, worked in the adjoining hospital at the dialysis center. The DNS</p>	F 686			

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F 686	<p>Continued From page 22</p> <p>stated RN #2 completed the dressing changes and obtained and updated wound care orders. The DNS stated RN #2 determined Resident #3's pressure ulcer was a Kennedy ulcer. The DNS was unable to describe a Kennedy ulcer or the characteristics of one.</p> <p>On 6/20/19 at 8:57 AM, RN #2 stated her position at the hospital was the Facility Administrator over dialysis and chemotherapy. She stated she also provided wound care to the residents in the skilled nursing facility. RN #2 stated Resident #3's wound started about a year ago. She identified it as a Kennedy ulcer because at that time Resident #3 was not expected to live. RN #2 stated terminal ulcers, though not expected to, could improve. RN #2 stated Resident #3's physician saw the Kennedy pressure ulcer, but it had been a little while, probably a few months. RN #2 stated the physician completed rounds in the facility on Thursdays. Resident #3's bath days were Tuesdays and Fridays, so the wound was usually covered when the physician made rounds. RN #2 stated she told the physician what she saw, and he told her what she should do. RN #2 stated on occasion the facility sent residents to the wound clinic, but the wound clinic was not in the local area and sometimes the health of the residents did not allow that.</p> <p>RN #2 stated the pressure ulcer was almost completely closed, then got worse, and now it was better. RN #2 stated treatment should be changed if the wound did not improve over two weeks. RN #2 reviewed Resident #3's assessments and stated using the same treatment was not the reason the ulcer did not heal over the past year. She stated the lack of</p>	F 686			

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F 686	<p>Continued From page 23</p> <p>healing was not related to Resident #3's positioning. RN #2 said it was the nutritional aspect that determined whether the wound improved or not. RN #2 said the treatment of Resident #3's pressure ulcer had been constant and only changed if the dressing requirements changed, such as if the ulcer got deeper and needed to be packed.</p> <p>Resident #3's weight records for the past 6 months were documented as follows:</p> <ul style="list-style-type: none"> *1/29/19 119.5 pounds *3/26/19 117.5 pounds *4/30/19 119 pounds *5/28/19 116 pounds *6/11/19 112.5 pounds <p>Resident #3's weight was relatively stable over 5 of the 6 months, ranging from 119.5 pounds to 116 pounds between 1/29/19 and 5/28/19.</p> <p>Resident #3's 8/16/18 through 6/7/19 (10 months) wound assessments defined her pressure ulcer as a Kennedy terminal ulcer. As previously stated, the National Pressure Ulcer Advisory Panel, dated March 2017, describes a Kennedy pressure ulcer as pear shaped, always on the coccyx or sacrum, red, yellow, and black, sudden onset, and death is imminent. Resident #3's ulcer was not pear shaped and her death was not imminent (likely to occur at any moment) for 10 months.</p> <p>The facility failed to ensure:</p> <ul style="list-style-type: none"> *Measurements of Resident #3's open ulcer and surrounding area were consistently and 	F 686			

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F 686	<p>Continued From page 24 thoroughly documented.</p> <p>*Resident #3's pressure ulcer was monitored by a physician.</p> <p>*Alternate treatment options were considered for Resident #3's pressure ulcer when interventions were not effective.</p> <p>*Resident #3's care plan was updated to address her pressure ulcer and changes in its status.</p> <p>2. Resident #28 was admitted to the facility on 1/25/19, with multiple diagnoses which included dementia, anxiety, and depression.</p> <p>A quarterly MDS assessment, dated 5/3/19, documented Resident #28 had moderately impaired cognition, did not reject care, and required extensive assistance of 2 plus staff for bed mobility, transfers, dressing, and toileting. Resident #28 was frequently incontinent of bowel and bladder. The assessment documented she was not at risk of pressure ulcers.</p> <p>A care plan, dated 1/25/19, documented a focus related to Resident #28's limited physical mobility. The care plan did not describe what the limited physical mobility was. A new intervention, dated 5/7/19, directed staff to ensure Resident #28's brace was in place. The care plan did not direct staff to assess the skin under the brace.</p> <p>A care plan, dated 1/25/19 and revised on 5/24/19, documented Resident was at risk of skin alterations related to incontinence and decreased mobility. The interventions documented Resident #28 repositioned herself independently and staff were to ensure a gel cushion was in her wheelchair and recliner, and an air overlay on her bed.</p>	F 686			

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F 686	Continued From page 25 A nursing progress note, dated 4/25/19, at 5:22 PM, documented Resident #28 fell in the bathroom and was diagnosed with a left tibial plateau fracture (a crack or break in the upper most portion of the shin bone that attaches to the knee joint). A nursing progress note, dated 4/25/19 at 7:50 PM, documented the placement of a universal knee immobilizer to Resident #28's left leg. The physician entered orders for non-weight bearing, may transfer to commode, chair, and knee immobilizer on at all times. A follow up 3 view x-ray of left knee was ordered for 5/6/19. A Physician's Order Summary Report documented Resident #28 was to wear a knee immobilizer at all times, every day and night shift, dated 4/26/19. The order did not direct staff to check the skin under the brace. A Skin/Wound Note, dated 5/21/19 at 12:51 PM, documented a 5 cm by 6 cm red area on Resident #28's sacrum with 3 small purple non-blanchable areas, and in the center there was an area that looked like it may open but was closed. A gel cushion was to be used in the wheelchair and the recliner, an air overlay was placed on Resident 28's bed, and staff were directed to reposition her every hour. Wound Assessments, dated 5/24/19, documented: *The presence of an in-house acquired pressure ulcer. The assessment documented Resident #28 had an open area to the center of her gluteal	F 686			

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F 686	<p>Continued From page 26</p> <p>fold and the surrounding tissue was red. On the right side there was a 1.3 cm x 0.5 cm area that was fading in color. Resident #28 had an air overlay on her bed and a gel cushion to her wheelchair and recliner. The wound measurements were documented as 15 mm in length x 4 mm in width x 1 mm in depth.</p> <p>*The presence of an in-house acquired pressure ulcer to Resident #28's right heel. The assessment documented there was a 1 cm x 0.5 cm light purple area to the center of the heel that did not blanch and a heel elevator boot was placed on 5/23/19 when staff reported concern. The wound measurements were documented on the assessment to be 17 mm in length x 13 mm in width x 0 mm in depth.</p> <p>A Physician Visit Note, dated 5/28/19, did not address Resident #28's sacral pressure ulcer.</p> <p>A nursing note, dated 6/5/19 at 6:20 PM, documented the immobilizer was to be off while Resident #28 was in bed and when sitting. The note directed staff to use the immobilizer with ambulation for 2 weeks and then it may be removed.</p> <p>A Physician Visit, dated 6/6/19, documented "Showed RN #2 a picture of the right heel and she will assess in the morning. Feels as long as it is not open, to leave it for now. Consider a better heel protector and ? dressing. Mepilex with border to left calf. Keep brace off when not walking/transferring." The note did not address the sacral/gluteal pressure ulcer.</p> <p>Resident #28's care plan, dated 6/7/19,</p>	F 686			

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F 686	<p>Continued From page 27</p> <p>documented the focus as "[specify name] has a pressure ulcer of the [specify location(s)] r/t." The interventions directed staff to assess, record and monitor the wound healing weekly. If there was no improvement in the wound over a two-week period staff were to notify the physician and consider changing treatments. The second intervention was to provide dietary supplements per the physician's order. The care plan did not include the locations of Resident #28's pressure ulcers.</p> <p>A Nutrition/Dietary note, dated 6/12/19 at 5:41 PM, documented acknowledgement of Resident #28's wound to her buttocks (sacral/gluteal), left lower leg, and heel.</p> <p>Wound Assessments, dated 6/7/19, documented:</p> <p>* The assessment described Resident #28's wound bed as "a white/grey slough." The note documented the wound was cleansed with wound cleaner, patted dry, dressed using sterile packing and covered with a Mepilex border dressing. The wound measurements were documented on the assessment to be 15 mm in length x 9 mm in width x 3 mm in depth. The assessment documented the wound was declining and was deeper and slightly wider than it was previously. The assessment documented the pressure ulcer as unstageable (full thickness skin and tissue loss in which the extent of the tissue damage cannot be confirmed because the wound bed is obscured with slough or eschar [dead or devitalized tissue].) The assessment did not identify the location of the wound. It was determined the assessment related to Resident #28's sacral/gluteal pressure ulcer as</p>	F 686			

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F 686	<p>Continued From page 28</p> <p>assessments of Resident #28's other two pressures, one on the right heel and another on the back Resident #28's left lower leg, were completed on the same date.</p> <p>*The right heel pressure ulcer measuring larger and was maroon in color, spongy, and had deep purple edges. The assessment documented "I talked with MD yesterday about leaving the skin intact for now and using it as a natural band aid. I talked to him about dressing it and advised him that as long as it was not open or draining to leave the dressing off at this time." The wound measurements were documented on the assessment to be 45 mm in length x 45 mm in width x 0 mm in depth.</p> <p>*The assessment documented an in-house acquired pressure ulcer to the back of Resident 28's left lower leg. The assessment documented staff removed the immobilizer a few days ago and noticed discoloration on the left distal calf. The assessment documented the area did not blanch and skin was sloughing in areas causing drainage. The wound measurements were documented on the assessment to be 45 mm in length x 13 mm in width x 0 mm in depth. The immobilizer was assessed, there was a hard metal support that ran down the back of the device, from the top to the bottom and fit right over the ulcer. The assessment documented sheepskin was applied to the brace and Mepilex with border was placed to protect the pressure ulcer.</p> <p>On 6/20/19 at 9:25 AM, RN #2 stated Resident #28's daily skin checks should have been done. The facility was unable to provide documentation</p>	F 686			

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F 686	Continued From page 29 of daily skin checks completed for Resident #28. On 6/20/19 at 10:15 AM, RN #1 stated when a resident had a brace, she would check for CMS (Circulation, Motion, Sensation) and document her assessment on the treatment sheets. RN #1 did not specify if she removed the brace to assess the skin under the brace. Resident #28's treatment sheets did not include daily skin checks. The facility failed to ensure Resident #28 was provided the care and services necessary to prevent the development of 3 pressure ulcers, one becoming unstageable.	F 686			
F 727 SS=E	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure an RN was on duty 8 hours a day 7 day a week to	F 727	F727 1. Residents potentially affected were reviewed and no adverse effects noted on	7/31/19	

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F 727	<p>Continued From page 30</p> <p>provide care and treatment to the residents. This was true for 4 of the 21 days reviewed. This affected 8 of 8 (#1, #3, #13, #14, #15, #17, #28, and #33) residents residing in the facility and had the potential to affect the other 26 residents residing in the facility. This created the potential for harm if residents' nursing needs went unmet. Findings include:</p> <p>The facility's Three-Week Nursing Schedule from 5/26/19 to 6/15/19, documented there was no RN coverage on 5/27/19 and 6/2/19 and had less than 8 consecutive hours of RN coverage on 6/1/19 and 6/3/19.</p> <p>This created the potential for the routine and emergency nursing needs of Residents #1, #3, #13, #14, #15, #17, #28, and #33, as well as the other 26 residents residing in the facility, to go unmet.</p> <p>On 6/19/19 at 2:30 PM, the Administrator stated the facility did not have RN coverage on 6/2/19 and 6/27/19. The Administrator stated the facility had 2 hours of RN coverage on 6/3/19 and 7.5 hours on 6/1/19. The Administrator stated it is sometimes difficult to get RN coverage.</p>	F 727	<p>the days specified with a lack of RN coverage. RNs and physicians were available at all times if needed in the attached hospital on all days mentioned without RN coverage.</p> <p>2. All residents have the potential to be affected by this alleged deficient practice.</p> <p>3. RN job postings & recruiting efforts have been in place since 4/9/2019. Efforts will continue to be made to hire more RNs. DON will review monthly work schedules to ensure RN coverage is in place.</p> <p>4. DON or designee will review licensed nurse schedules weekly x4 then monthly x2 to ensure RN coverage is scheduled according to requirements and report findings to the QAPI committee for further recommendation.</p>		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001030	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/20/2019
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NAME OF PROVIDER OR SUPPLIER BEAR LAKE MEMORIAL SKILLED NURSING F/	STREET ADDRESS, CITY, STATE, ZIP CODE 164 SOUTH FIFTH STREET MONTPELIER, ID 83254
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C 000	INITIAL COMMENTS The following deficiency was cited during the state licensure survey conducted at the facility from June 16, 2019 through June 20, 2019. The surveyors conducting the survey were: Edith Cecil, RN, Team Coordinator Presie C. Billington, RN	C 000		
C 664	02.150,02,a Required Members of Committee a. Include the facility medical director, administrator, pharmacist, dietary services supervisor, director of nursing services, housekeeping services representative, and maintenance services representative. This Rule is not met as evidenced by: Based on staff interview and review of Infection Control Committee (ICC) attendance records, it was determined the facility failed to ensure a representative from each department attended their quarterly Infection Control Meetings. The lack of participation of all departments created the potential for negative outcomes for residents, visitors and staff in the facility. Findings included: On 6/19/19 at 9:10 AM, the facility's Infection Control Program was reviewed with the Infection Control Nurse (ICN). The ICN provided ICC attendance records dated 9/4/18, 1/8/19, 4/2/19, and 6/11/19. Upon review of the sign-in sheets, it was determined the following departments were not represented: * Pharmacist for 9/4/18, 1/8/19, and 6/11/19 meetings * Dietary Manager (DM) for 4/2/19 meeting	C 664	C664 1. No residents were found to have been affected by this alleged deficient practice. 2. All residents have the potential to be affected by this alleged deficient practice. 3. Members of the committee who were not in attendance at some of the meetings who are required to attend were reminded of this requirement on 6/20/2019. Meeting invitations/reminders will continue to be sent to all members of the committee. If department heads aren't able to attend in person they will either send a representative from their department or join the meeting by phone. 4. Administrator or designee will review meeting attendance quarterly x2, any concerns will be addressed immediately and discussed with the QAPI committee for further recommendations.	7/31/19

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 07/15/19
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Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001030	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/20/2019
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NAME OF PROVIDER OR SUPPLIER BEAR LAKE MEMORIAL SKILLED NURSING F/	STREET ADDRESS, CITY, STATE, ZIP CODE 164 SOUTH FIFTH STREET MONTPELIER, ID 83254
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C 664	Continued From page 1 * Maintenance for 6/11/19 On 6/19 19 at 4:18 PM, the Administrator said they held their ICC quarterly. The Administrator said the Pharmacist, DM, and a representative from the Maintenance Department were unable to attend some of their quarterly meetings.	C 664		