



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

TAMARA PRISOCK—ADMINISTRATOR
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BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
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January 26, 2016

Joshua Bowman, Administrator
Teton Post Acute Care & Rehabilitation
3111 Channing Way
Idaho Falls, ID 83404-7534

Provider #: 135138

Dear Mr. Bowman:

On **January 11, 2016**, a survey was conducted at Teton Post Acute Care & Rehabilitation by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be 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.

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **February 8, 2016**. Failure to submit an acceptable PoC by **February 8, 2016**, may result in the imposition of civil monetary penalties by **February 28, 2016**.

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

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

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

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

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

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **March 1, 2016 (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 **March 1, 2016**. A change in the seriousness of the deficiencies on **March 1, 2016**, may result in a change in the remedy.

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The remedy, which will be recommended if substantial compliance has not been achieved by **March 1, 2016** includes the following:

Denial of payment for new admissions effective **April 11, 2016**. [42 CFR §488.417(a)]

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

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **July 11, 2016**, 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 David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 2; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **January 11, 2016** 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>

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

- BFS Letters (06/30/11)

2001-10 Long Term Care Informal Dispute Resolution Process
2001-10 IDR Request Form

This request must be received by **February 8, 2016**. If your request for informal dispute resolution is received after **February 8, 2016**, 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 David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2.

Sincerely,

A handwritten signature in black ink, appearing to read "Nina Sanderson". The signature is written in a cursive style with a large initial "N".

Nina Sanderson, LSW, Supervisor
Long Term Care

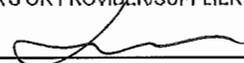
NS/lj
Enclosures

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

PRINTED: 01/26/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135138	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/11/2016
NAME OF PROVIDER OR SUPPLIER TETON POST ACUTE CARE & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 3111 CHANNING WAY IDAHO FALLS, ID 83404	
(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	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the federal recertification and complaint survey conducted from January 4, 2016 to January 11, 2016.</p> <p>The surveyors conducting the survey were: Linda Kelly, RN, Team Leader Preslie Billington, RN Kendra Deines, RN</p> <p>Abbreviations:</p> <p>BID = Twice a day BIMS = Brief Interview for Mental Status BP = Blood pressure cc = Cubic Centimeter CNA = Certified Nursing Assistant CPAP = Continuous Positive Airway Pressure DON = Director of Nursing ER = Extended Release fr = French L = Liters l/min = Liters per minute LN = Licensed Nurse LSW = Licensed Social Worker MAR = Medication Administration Record MD = Medical Doctor MDS = Minimum Data Set mg = milligram(s) MRM = Medical Records Manager N/C = Nasal cannula NO = New Order NS = Normal Saline O2 = Oxygen PRN = As needed QD = Everyday RM = Rehabilitation/Rehab Manager</p>	F 000	<p><u>DISCLAIMER CLAUSE</u></p> <p>PREPARATION AND/OR EXECUTION OF THIS PLAN OF CORRECTION DOES NOT CONSTITUTE THE PROVIDER'S ADMISSION OF OR AGREEMENT WITH THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THE STATEMENT OF DEFICIENCIES. THE PLAN OF CORRECTION IS PREPARED AND/OR EXECUTED SOLELY BECAUSE IT IS REQUIRED BY THE PROVISIONS OF FEDERAL AND STATE LAW.</p> <p>F 176</p> <p>1. How was corrective action accomplished for the identified residents? Resident's #18 medications were removed from resident bedside until resident successfully completed self med assessment with OT, lock box provided at bedside.</p> <p>2. How will you identify other residents with the potential of being affected by the same practice? Residents residing in the facility have the potential to be affected. A Facility wide audit of residents done, no other medications found at bed-sides. Residents who are identified as wanting to self-administer their medications will be assessed prior to the medications being allowed at their bedside.</p>	

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



TITLE

Administrator

(X6) DATE

2/22/2016

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 000	Continued From page 1 r/t = Related to sats = Oxygen saturation SOB = Short(ness) of breath TAR = Treatment Administration Record UTI = Urinary Tract Infection w/c = Wheelchair	F 000		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, it was determined the facility failed to ensure residents who wished to self-administer medications were safe to do so. This was true for 1 of 2 random residents (#18) and created the potential for medication errors if the resident was not competent to self-administer medications. Findings included: On 1/7/2016 at 8:35 am, the following were observed on the over-bed table of Random Resident #18. *A bottle of Advil 200 mg. The resident said he took the Advil for his lower back pain. *An Albuterol Sulfate inhaler. The resident said he used the inhaler when he was having shortness of breath. *A tube of Preparation H cream *A bottle of Melatonin *A Systane Gel eye drop *Fluticasone Propionate nasal spray	F 176	3. Address what measures will be put in place to ensure deficient practice will not recur. Nurses will be re-educated that residents who want to self-administer their meds need to complete the self medication assessment with OT or RN. Educate nurses to ask the questions under CHOICES to see if they want to self medicate. Daily clinical meeting will audit self medication and discuss plan with the resident. SDC to re-educate. 4. How will the plan be monitored to validate the solutions are sustained? Facility will monitor residents currently self-administering medications to validate the self-medication assessment has deemed resident safe for self-medication. Facility will audit new admits to see if self-medication is offered. Audits will be completed 3 x weekly for 4 weeks, then 2 x weekly for 4 weeks, then 1 x weekly for 4 weeks. DNS/Designees to complete. 5. Corrective action will be completed by February 24th, 2016. ED/ DNS responsible for compliance.	

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F 176	Continued From page 2	F 176			
F 246 SS=D	<p>On 1/7/2016 at 8:45 am, LN #4 was shown the medications in Random Resident #18's room. LN #4 said Random Resident #18 was not assessed to self-administer medications safely and his medical record did not contain a self-administer assessment.</p> <p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES</p> <p>A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure fluids were accessible for 1 of 10 sample residents (#5) during a meal in the dining room. The failure created the potential for the resident to be thirsty. Findings included:</p> <p>Resident #5 was admitted to the facility 11/12/15 with multiple diagnoses, including left wrist fracture.</p> <p>A cast was observed on the resident's left arm multiple times on 1/5/16 through 1/7/16. The left arm cast was distal to the resident's elbow down to the first knuckle of the fingers and between the fingers and thumb.</p>	F 246	<p>F 246</p> <ol style="list-style-type: none"> How was corrective action accomplished for the identified residents? Resident #5 fluids were moved to the right side of the place setting. How will you identify other residents with the potential of being affected by the same practice? Residents residing in the facility have the potential to be affected. Residents with restrictive devices to upper extremities or residents who have an affected side, will be identified and care plan updated. Address what measures will be put in place to ensure deficient practice will not recur. Staff will be re-educated on proper placement of utensils and cups for residents with restrictive devices in place, or residents with an affected side. SDC/DNS to do the re-education. 		

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F 246	Continued From page 3 On 1/5/16 at 12:10 pm, during the lunch meal service, three glasses of liquids were observed on the table in front of and to the left of the resident. At 12:19 pm, the meal was served directly in front of the resident. The resident used her right hand to eat independently. The resident did not attempt to pick up any of the glasses. At 12:37 pm, when asked if she could reach the drinks, the resident said "No." At 12:38 pm, CNA #9 moved the 3 glasses to the resident's right side and the resident began to pick up the glasses and drink the fluids. The liquids were not accessible for the resident's for 28 minutes before that. Immediately afterward, CNA #9 said "I should have paid closer attention" and should have placed the glasses of fluids on the resident's right side.	F 246	4. How will the plan be monitored to ensure the solutions are sustained? Meal audits of the residents requiring special placement of utensils, cups, 3 x weekly for 4 weeks, then 2 x weekly for 4 weeks, then 1 x weekly for 4 weeks. Results will be brought to CQI monthly. ED/DNS/designee to do the audits. 5. Corrective action will be completed by February 24th, 2016. ED/ DNS responsible for compliance.		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed	Text F 280			

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F 280	<p>Continued From page 4 and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to revise or update the care plans for 3 of 7 sample residents (#s 1, 5 and 6). The failure created the potential for harm if care was provided or treatment decisions were made based on outdated or inaccurate information regarding a communication pad and non-slip floor mat for Resident #5, a non-slip floor mat and low bed for Resident #6, and the size of Resident #1's indwelling urinary catheter. Findings included:</p> <p>1. Resident #5 was admitted to the facility 11/12/15 with multiple diagnoses including left wrist fracture.</p> <p>The resident's 11/19/15 admission MDS assessment documented moderately impaired cognition with short- and long-term memory loss and functional limitation in range of motion in one upper and one lower extremity.</p> <p>The resident's 11/13/15 "Alteration in Communication Initial Care Plan" approaches included a communication notebook or pad within the resident's reach. The 11/13/15 "Fall Risk Care Plan" approaches included "non-slip" mats at bedside.</p> <p>A notebook/pad for writing and non-slip mats were not observed in the resident's room on</p>	F 280	<p>F 280</p> <p>1. How was corrective action accomplished for the identified residents? The care plan for Resident #5 was updated to reflect she no longer needs a matt on the floor or the notebook at her bedside. Resident # 6's care plan was updated to reflect she no longer needs a matt on the floor or her bed in the low position. Resident #1's care plan was updated to reflect accurate foley size.</p> <p>2. How you will identify other residents with the potential of being affected by the same practice? Residents residing in the facility have the potential to be affected. Facility wide audit to validate careplans are current and accurate. DNS/designee to do the audits.</p> <p>3. Address what measures will be put in place to ensure deficient practice will not recur. Staff re-educated on the uses of devices in the facility and the need for accurate care planning. During clinical meeting care plans will be audited to validate that they are accurate. Re-education to be done by DNS/SDC.</p>		

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F 280	<p>Continued From page 5 1/5/16 at 2:34 pm and on 1/6/16 at 8:00 am and 10:50 am.</p> <p>On 1/6/16 at 11:45 am, LN #7 said the resident's care plan for a communication notebook/pad and non-slip floor mat was incorrect and needed to be revised.</p> <p>2. Resident #6 was admitted to the facility 5/26/15 with multiple diagnoses, including hypertension.</p> <p>The resident's most recent quarterly MDS assessnebt, dated 11/18/15, documented moderately impaired cognition with short- and long-term memory loss, extensive assistance for bed mobility and toileting, total assistance for transfers, only able to stabilize with assistance when moving on and off the toilet and surface-to-surface transfers, and no falls since admission.</p> <p>The resident's 5/29/15 Fall Risk Care Plan approaches included non-slip mats at bedside and a lowered bed or mattress on the floor.</p> <p>The resident was observed in bed with the bed in a raised position and no mats at bedside or in the resident's room on 1/5/16 at 9:35 am and 10:45 am, 1/6/16 at 9:30 am and 10:45 am, and 1/7/16 at 10:15 am.</p> <p>On 1/7/16 at 10:15 am, the resident said the bed was "always as it is now," and "I never had any mats on the floor."</p> <p>On 1/7/16 at 4:30 pm, the DON said a lowered bed and non-slip mats at bedside were needed when the resident was admitted, "But they are no</p>	F 280	<p>4. How will the plan be monitored to ensure the solutions are sustained? Audit of careplans in use 3 x weekly for 4 weeks, then 2 x weekly for 4 weeks, then 1 x weekly for 4 weeks. Results will be brought to CQI meetings monthly. Audits will be done by ED/DNS/designee.</p> <p>5. Corrective action will be completed by February 24th, 2016. ED/DNS responsible for compliance.</p>		

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F 280	Continued From page 6 longer needed," and the care plan should have been revised. 3. Resident #1 was admitted to the facility on 1/22/2015 with multiple diagnoses, including urinary tract infection. Resident #1's recapitulated December 2015 Physician's Order and MAR documented an order dated 10/24/2015: "Foley Catheter 20 French/10 cc balloon." On 1/7/2016 at 12:03 pm, the DON and surveyor went to Resident #1's room and checked the size of in-dwelling catheter, which was 20 French. The DON said the care plan was incorrect and needed to be updated.	F 280			
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure medications were not initialed as given on the Medication Administration Record prior to the administration of the medication. This was true for 1 of 10 (#2) sampled residents and 2 of 3 (#s 18 & 20) random residents during the medication pass observation. This failed practice had the potential for harm if residents were documented as having received medications they either refused or were not given. Findings included:	F 281	F 281 1. How was corrective action accomplished for the identified residents? Resident's #2,18,20 all received the proper medications, 2. How will you identify other residents with the potential of being affected by the same practice? Residents residing in the facility have the potential to be affected. Audit of MARS and resident medications to validate they received the proper medication. Audits to be done by ED/DNS/designee. 3. Address what measures will be put in place to ensure deficient practice will not recur. Nurses to be re-educated on the proper medication documentation protocol. Re-education piece will also be added to our general orientation topics for nurses. Re-education to done by SDC/DNS.		

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F 281	Continued From page 7 The following observations were made during the survey week from 1/4/16 - 1/8/16: On 1/5/16 at 9:10 am, LN #1 was observed pre-initialing Resident #2's Omeprazole 20 mg BID on the MAR prior to its actual administration. At 9:45 am, LN #1 said she initialed the MAR after she placed the medication into the medication cup and would circle her initial if the resident refused to take the medication. On 1/6/16 at 10:45 am, LN #3 was observed pre-initialing Random Resident #20's "Tramadol 50 mg PRN every 4 hours" on the MAR prior to actual administration of the medication. LN #3 was asked how he would document the medication administration to the resident. LN #3 stated that he was aware the State would like the nurses to place a dot on the MAR when the medication was prepared, but "unfortunately I initialed it already." On 1/7/16 at 8:30 am, LN #6 was observed pre-initialing Random Resident #18's "Zofran 4 mg PRN for nausea" on the MAR prior to actual administration of the medication. LN #6 stated she initialed the resident's MAR before giving the medication to the resident.	F 281	4. How will the plan be monitored to ensure the solutions are sustained? Audits of the nurse during med pass to validate proper medication documentation procedure is being followed. Audits to be done 3 x weekly for 4 weeks, then 2 x weekly for 4 weeks, then 1 x weekly for 4 weeks. Audits will be done by DNS/ED/ designee. 5. Corrective action will be completed by February 24th, 2016. ED/ DNS responsible for compliance.		
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309	F 309 1. How was corrective action accomplished for the identified residents? Resident #1's orthostatic BP has been obtained. CPAP has been cleaned. The care plan has been updated to reflect she no longer needs the bed in the low position or a matt on the floor. Resident #4 received her full course of antibiotics. Resident #5 had her cast removed and new orders obtained for podus boots. Resident #6 orthostatic BP obtained. Resident #7 received his B12 injection. Resident #9 psych meds were reviewed, order accurately reflects the dose given.		

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F 309	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record review, it was determined the facility failed to ensure physician orders and care plans were followed for 6 of 10 sample residents (#s 1, 4, 5, 6, 7 & 9). The failure created the potential for harm when Resident #1's orthostatic BP was not checked, CPAP was not consistently cleaned, low bed and fall mat were not in place; Resident #4's antibiotic was not administered; Resident #5's arm cast was not removed and Podus boot was not on at all times; Resident #6's orthostatic BP was not checked; Resident #7's vitamin B-12 injections were not administered; and Resident #9's orders for an antipsychotic medication were not followed. Findings included: 1. Resident #5 was admitted to the facility 11/12/15 with multiple diagnoses, including left wrist fracture. The resident's 11/19/15 admission MDS assessment coded moderately impaired cognition with short- and long-term memory loss, functional limitation in range of motion in one upper and one lower extremity and one unstageable pressure ulcer present on admission. a. A 12/9/15 physician's order directed referral to a limb and brace company for removal of the resident's left arm cast and to fit and apply a wrist/forearm removable brace on 12/23/15. The resident was observed with the left arm cast still in place on 1/4/16 through 1/7/16.	F 309	2. How will we identify other residents with the potential of being affected by the same practice? Residents residing in the facility have the potential to be affected. DNS/ Designee to complete facility wide audit to confirm MARS/TARS are in accordance with physician orders and care plans are updated. Changes to orders will be validated during the RECAP and clinical meeting process. Audits to be completed by DNS/ED/ designee. 3. Address what measures will be put in place to ensure deficient practice will not recur. The root cause has been determined that non-compliance with this citation is due to inadequate training of licensed nurses addressing documentation and following physician orders. The DNS/SDC/Designee will expand the general orientation of licensed nurses to include, but not be limited to, comprehensive exposure to EmpRes policy and procedures, care plans, following physician orders, and the expectations addressing the standards of practice in the area of documentation. The DNS/SDC/Designee will provide additional training for current licensed nurses to include, but not be limited to, comprehensive exposure to EmpRes policy and procedures, care plans, following physician orders, and the expectations addressing the standards of practice in the area of documentation.		

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F.309	<p>Continued From page 9</p> <p>On 1/6/16 at 11:10 am, LN #7 said the order for cast removal was given to the RM.</p> <p>On 1/8/16 at 4:00 pm, the RM said she found the order regarding the resident's cast removal on her desk. The RM said she did not know who put it there and when she asked about the order during the daily clinical meeting no one responded. The RM said because the order was not therapy related, she did not act upon it or notify other staff. She stated, "There was a lack of communication."</p> <p>b. The resident's 12/14/15 wound clinic physician's order documented, "Keep weight off affected area/limb at all times," and "Off-loading Device - Multipodus boot - sent with patient."</p> <p>Two other wound clinic physician's orders, dated 12/21/15 and 1/4/16, both instructed the multipodus boot was to be worn "at all times."</p> <p>The resident's 12/15/15 care plan for pressure ulcers documented "podus boots at all times," and "treatment at wound clinic."</p> <p>The resident's 11/12/15 Nursing Admission Evaluation documented an unstageable right heel pressure ulcer was present on admission.</p> <p>Wound clinic notes for 12/21/14 and 1/4/16 documented the multipodus boot was not in place on those days.</p> <p>On 1/5/16 and 1/6/16, the resident was observed in bed numerous times with a padded dressing on her right foot and not wearing a multipodus boot on the right foot.</p>	F.309	<p>The DNS/SDC/Designee will provide additional training for current licensed nurses to include, but not be limited to, comprehensive exposure to EmpRes policy and procedures, care plans, following physician orders, and the expectations addressing the standards of practice in the area of documentation. The DNS/SDC/Designee, approximately two (2) weeks after general orientation of licensed nurses, will conduct additional training in the areas of EmpRes policy and procedures, care plans, following physician orders, and the expectations addressing the standards of practice in the area of documentation.</p> <p>The DNS/SDC/Designee will address the areas of EmpRes policy and procedures, care plans, following physician orders, and the expectations addressing the standards of practice in the area of documentation in the monthly licensed nurse's meeting, assess the need for additional training as supported by the random weekly audits, and provide the training during the meeting.</p>		

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F 309	<p>Continued From page 10</p> <p>On 1/6/16 at 11:10 am, LN #7 said the resident's multipodus boot was to be worn "only when in bed because it's a fall risk." The LN said the order for the multipodus boot had not been clarified and that she would clarify it with the wound clinic.</p> <p>2. Resident #6 was admitted to the facility 5/26/15 with multiple diagnoses, including hypertension.</p> <p>The resident's January 2016 recapitulated physician's orders included Elavil and Lasix, both of which included orthostatic hypotension as a potential adverse reaction. Both medications were ordered 5/26/15. The recapitulation orders also included monthly orthostatic BP checks starting 5/26/15.</p> <p>The resident's December 2015 MAR included the same orders for Elavil and Lasix with the related orthostatic BP checks. The MAR documented the medications were administered but that the monthly orthostatic BP check was not done in December.</p> <p>On 1/7/16 at 4:30 pm, the DON reviewed the resident's physician orders and MARs regarding orthostatic B/P checks and stated, "They're not being done."</p> <p>3. Resident #7 was admitted to the facility 10/14/15 with multiple diagnoses, including unspecified vitamin deficiency.</p> <p>The resident's 10/14/15 admission orders included an order for vitamin B 12 injections every week for 3 weeks, then every 2 weeks for 4 weeks, then monthly thereafter for vitamin B 12 deficiency.</p>	F 309	<p>4. How will the plan be monitored to ensure the solutions are sustained?</p> <p>Care plans and physician orders are monitored for accuracy in our clinical meeting. Audits will be done of care plans, MARS/TARS and physician orders 3 x weekly for 4 weeks, then 2 x weekly for 4 weeks, then 1 x weekly for 4 weeks. Audits will be completed by ED/DNS/designee.</p> <p>The DNS/SDC/Designee will conduct random weekly audits for six (6) months evaluating care plans accuracy, following physician orders, and standards of practice addressing documentation compliance.</p> <p>The DNS/SDC/Designee will determine the needs of additional training from communication received during the monthly licensed nurse's meeting and the results of the random weekly audits in the areas of EmpRes policy and procedures, care plans, following physician orders, and the expectations addressing the standards of practice in the area of documentation.</p> <p>The DNS/SDC/Designee will audit MAR's and TAR's in the clinical meeting five (5) times per week to validate that documentation is complete.</p>		

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F 309	<p>Continued From page 11</p> <p>The resident's MARs for October, November and December 2015 documented the vitamin B 12 injections were administered as ordered in October and November. The MARs documented that B 12 injections were not administered in December.</p> <p>On 1/7/16 at 3:45 pm, the DON reviewed the resident's orders and MARs then said vitamin B 12 injections were not administered in December 2015.</p> <p>4. Resident #9 was admitted to the facility 10/1/15 with multiple diagnoses, including schizoaffective disorder and depression.</p> <p>A 10/30/15 Telephone Order increased the resident's Abilify from 2.5 mg daily to 5 mg daily.</p> <p>The resident's October 2015 MAR documented that Abilify 5 mg was administered on 10/30 and 10/31/15.</p> <p>The November 2015 MAR included the order for Abilify 2.5 mg daily and documented the resident was administered Abilify 2.5 mg from 11/1/15 - 11/28/15 (refer to F 425). The MAR did not include the order for Abilify 5 mg daily (refer to F 514).</p> <p>On 1/7/16 at 4:45 pm, the DON said the resident's physician order for Abilify 5 mg daily was not followed in November 2015.</p> <p>5. Resident #1 was admitted to the facility on 1/22/15 with multiple diagnoses, including respiratory tract distress and hypertension.</p>	F 309	<p>5. Corrective action will be completed by February 24th, 2016. ED/DNS responsible for compliance.</p>		

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F 309	<p>Continued From page 12</p> <p>The resident's physician's orders and MARs for November and December 2015 documented an order dated 2/12/15 directing staff to "take orthostatic BP in this order lying, sitting and standing."</p> <p>The resident's November and December TAR documented orthostatic BP were not completed.</p> <p>On 1/6/2016, LN #4 looked at Resident #1's medical record for orthostatic BP documentation and stated those BP's were not in the record.</p> <p>b. Resident #1's recapitulated physician's orders for November and December 2015 documented an order dated 4/16/15 to place the resident's bed in low position with a floor mat at bedside for injury prevention.</p> <p>The resident's 4/16/15 Fall Risk Care Plan was updated to reflect the physician's order.</p> <p>On 1/5/16 at 10:00 am and on 1/6/16 at 12:00 pm, the resident was observed in bed that was not in low position and no floor mat was at bedside.</p> <p>On 1/6/2016 at 12:30 pm, LN #4 said she did not see the floor mat and the bed was not in the low position.</p> <p>c. Resident #1's November and December 2015 recapitulated physician's orders dated 2/12/15 documented an order for the staff to rinse the CPAP/BIPAP mask daily with water and and air dry during day shift.</p> <p>The November and December 2015 TAR documented "multiple holes" in documentation of</p>	F 309			

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F 309	Continued From page 13 the mask being cleaned. On 1/7/16 at 11:30 am, CNA #10 said she cleaned the mask whenever she was on duty. When asked if she documented it. CNA #10 said "No." 6. Resident #4 was admitted to the facility on 12/30/15 with multiple diagnoses, including pneumonia. The resident's December 2015 Physician's Order documented Resident #4 to receive Levaquin 500 mg PO daily for 7 days beginning 12/30/15. Resident #4 's December MAR documented, Levaquin was started on 12/31/15. On 1/6/16 at 11:00, DON said resident should have received the Levaquin on 12/30/15, but she could not confirm that it was given.	F 309		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record	F 314	F 314 1. How was the corrective action accomplished for the identified residents? Resident #2's pressure ulcer has resolved.	

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F 314	<p>Continued From page 14</p> <p>review, it was determined the facility failed to ensure physician orders were followed for 1 of 2 sample residents (#2) for pressure ulcer. This failure created the potential for harm when wound care was not provided to a buttocks shear wound for Resident #2. Findings included:</p> <p>Resident #2 was admitted to the facility on 5/16/15. The resident had several admissions and discharges from the facility and was most recently readmitted on 12/31/15 with multiple diagnoses, including osteomyelitis and hypertensive chronic kidney disease. The resident went to dialysis every Monday, Wednesday and Friday.</p> <p>The resident's 9/17/15 quarterly MDS assessment documented intact cognition with a BIMS score of 15, and two person physical assist with bed mobility, transfers, dressing and toileting.</p> <p>The 11/2/15 Skin Integrity Care Plan documented the skin breakdown on both buttocks and a history of pressure ulcers to the buttocks. Approaches included, "dressing to area per MD order, pressure reducing mattress, pressure reducing chair device, apply protective lotion after shower/pericare ..."</p> <p>Resident's #2's 11/4/15 Event Investigation Report documented the resident's buttocks "as not looking good" with shearing to the left and right buttocks. The Final Summary of the Event Investigation documented, "Resident spends a lot of time sitting up in bed or in wheel chair, doesn't like to off-load, with history of pressure ulcers and non-compliant with treatment and prevention. W/C cushion evaluated and ok, resident in specialty bed RT size and needs. ...Hydrocolloid</p>	F 314	<p>2. How will you identify other residents with the potential of being affected by the same practice? Residents in the facility with pressure ulcers have the potential to be affected. DNS/designee will conduct a facility wide audit to validate telephone and physician orders get transcribed to the MARS/TARS and care plans updated.</p> <p>3. Address what measures will be put in place to ensure deficient practice will not recur.</p> <p>The root cause has been determined that non-compliance with this citation is due to inadequate training of licensed nurses addressing documentation and following physician orders. The DNS/SDC/Designee will expand the general orientation of licensed nurses to include, but not be limited to, comprehensive exposure to EmpRes policy and procedures, care plans, following physician orders, and the expectations addressing the standards of practice in the area of documentation. The DNS/SDC/Designee will provide additional training for current licensed nurses to include, but not be limited to, comprehensive exposure to EmpRes policy and procedures, care plans, following physician orders, and the expectations addressing the standards of practice in the area of documentation.</p>	

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F 314	<p>Continued From page 15 ordered for treatment, will continue to monitor and dressing changes."</p> <p>The 2015 November TAR documented Resident #2's buttocks was cleansed (9 times) with NS and hydrocolloid dressings were applied to the wound every three days and PRN from 11/1/15 to 11/22/15. There were no dressings changes from 11/23/15 to 11/30/15.</p> <p>Resident #2's Weekly Skin Evaluation, dated 11/1/15, 11/5/15 and 11/12/15, documented "shearing" and the back of the body diagram included a mark on the left and right buttocks. A 11/21/15 Weekly Skin Evaluation documented the wound was "resolved."</p> <p>A Weekly Skin Evaluation report dated 12/4/15 and 12/21/15 included back of a body diagram with a mark on the right buttock, and documented the wound bed as "pink/beefy red", Stage II."</p> <p>A 12/14/15 Physician's Telephone Order documented a new wound care order for Resident #2's buttocks to cleanse with NS and gauze, and apply barrier cream every day and PRN.</p> <p>The 12/14/15 wound order was not documented on the resident's 2015 December TAR.</p> <p>Nurses Notes documented the following: *12/14/2015 at 7:00 pm, "...NO wound care to Left and Right buttocks. ..." *12/18/2015 at 10:00 pm, "... Dressing on bottom changed. ..." *12/19/2015 at 9:50 am, "... Barrier cream to coccyx. ..." Note: There was no further documentation the</p>	F 314	<p>The DNS/SDC/Designee, approximately two (2) weeks after general orientation of licensed nurses, will conduct additional training in the areas of EmpRes policy and procedures, care plans, following physician orders, and the expectations addressing the standards of practice in the area of documentation.</p> <p>The DNS/SDC/Designee will address the areas of EmpRes policy and procedures, care plans, following physician orders, and the expectations addressing the standards of practice in the area of documentation in the monthly licensed nurse's meeting, assess the need for additional training as supported by the random weekly audits, and provide the training during the meeting.</p>	

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F 314	Continued From page 16 resident received wound care after 12/19/15. On 1/8/16 at 8:45 am, Resident #2's buttocks were observed as LN #1 changed the dressing. A scab was observed on the resident's left buttock, no open area was noted. The right buttock had an open area measure 2 x 3 cm; no odor or discharge was noted. There was a 6 x 8 cm reddening area which was blanchable. On 1/8/16 at 8:45 am, Resident #2 said she sat in a recumbent position and was unable to change position for at least five hours during her dialysis. When asked if she was being turned and repositioned by the facility staff, Resident #2 said "Yes." On 1/8/16 at 11:00 am, the DON said the resident's December 2015 TAR should have been updated with the new physician order. The DON also said the resident's skin injury was not a pressure ulcer, but was more of a "shearing" injury that had occurred before and healed quickly. She said the injury was superficial and could be due to the resident sliding down in bed and sitting for about five hours during dialysis sessions. When asked if the facility communicated with the dialysis center regarding the resident's need to turn and reposition regularly, DON said "No, we did not." She said the facility would inform the dialysis center of the pressure relieving device and send a cushion with the resident.	F 314	4. How will the plan be monitored to ensure the solutions are sustained? Facility to conduct random audits to validate care plans, MARS/TARS are in accordance with the physician orders, 3 x weekly for 4 weeks, then 2 x weekly for 4 weeks, then 1 x weekly. Audits will be brought to monthly CQI for review. Audits to be completed by ED/DNS/designee. The DNS/SDC/Designee will conduct random weekly audits for six (6) months evaluating care plans accuracy, following physician orders, and standards of practice addressing documentation compliance. The DNS/SDC/Designee will determine the needs of additional training from communication received during the monthly licensed nurse's meeting and the results of the random weekly audits in the areas of EmpRes policy and procedures, care plans, following physician orders, and the expectations addressing the standards of practice in the area of documentation. The DNS/SDC/Designee will audit MAR's and TAR's in the clinical meeting five (5) times per week to validate that documentation is complete. 5. Corrective action will be completed by February 24th, 2016. ED/DNS responsible for compliance.	
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a	F 315	1. How was the corrective action accomplished for the identified residents? Residents #7's foley has been dc'd.	

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PRINTED: 01/26/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135138	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/11/2016	
NAME OF PROVIDER OR SUPPLIER TETON POST ACUTE CARE & REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 3111 CHANNING WAY IDAHO FALLS, ID 83404		
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F 315	<p>Continued From page 17</p> <p>resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure an indwelling urinary catheter was changed as ordered, and the catheter was effectively secured for 1 of 4 residents (#7) reviewed for urinary catheters. This failure placed the resident at risk for UTI, discomfort, skin breakdown and decreased bladder function. Findings included:</p> <p>Resident #7 was admitted to the facility on 10/14/15 with multiple diagnoses, including resolved UTI and urinary retention.</p> <p>The resident's 10/24/15 admission MDS assessment coded intact cognition, extensive assistance for bed mobility and ambulation, total assistance with transfers, and an indwelling urinary catheter.</p> <p>A 10/12/15 urology Consultation Report documented, "Debility and weakness associated with recent onset of urinary retention..." Recommendations included, "...Foley catheter may be indicated...may need an indwelling catheter..."</p>	F 315	<p>2. How you will identify other residents with the potential of being affected by the same practice? Residents residing in the center with a foley catheter have the potential to be affected. Those residents have been assessed for the need of a securement device and one applied if needed. Their orders were checked for foley change orders that differ from our standing orders.</p> <p>3. Address what measures will be put in place to ensure deficient practice will not recur. Nurses and aides will be re-educated on following physician orders for foley care, and changing of the foley catheter. They will also be re-educated on the use of a foley securement device, where to find them, and how to apply them. SDC/DNS to re-educate.</p> <p>4. How will the plan be monitored to ensure the solutions are sustained? DNS/designee will conduct facility wide audit to validate that physician orders related to catheter orders are followed as ordered 3 x weekly for 4 weeks, then 2 x weekly for 4 weeks, then 1 x weekly for 4 weeks. Results will be brought to monthly CQI meeting for review. Audits will be completed by ED/DNS/designee.</p>	

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F 315	<p>Continued From page 18</p> <p>The resident's January 2016 physician's orders included a 10/14/15 order for a Foley catheter, and the 10/14/15 Nursing Admission Evaluation documented a Foley catheter was in place on admission.</p> <p>A 10/15/15 Bladder Evaluation Form documented the resident was incontinent of bladder. All other questions on the form, including the type of incontinence, were blank.</p> <p>A 10/16/15 order faxed from the urologist to the facility ordered Foley catheter change every four weeks "until able to walk."</p> <p>No other bladder evaluations or documents related to bladder function were found in the resident's record.</p> <p>TARs for November and December 2015 and January 2016 documented the resident's Foley catheter was changed 11/29/15 but not changed in December or January.</p> <p>The resident's urinary drainage tubing and/or urinary drainage bag were observed on four occasions on 1/5/16, once on 1/6/16 and once on 1/7/16.</p> <p>On 1/5/16 at 2:05 pm, the resident was observed propelling his wheelchair in the common TV room by the nurses' station. The resident pointed at his bladder area and said he was going to his room to check the catheter. At 2:50 pm, the resident was observed lying on his bed with the uncovered urinary drainage bag on the floor next to the bed (refer to F 441 regarding infection control). The resident said the catheter had pulled "really bad" and "caused bleeding" when he self transferred</p>	F 315	5. Corrective action will be completed by February 24th, 2016. ED/ DNS responsible for compliance.		

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F 315	Continued From page 19 into bed. The resident said he had not requested assistance with the transfer and that CNA #11 helped him after the transfer. No staff were in the resident's room at the time of this observation. On 1/5/16 at 2:53 pm, LN #1 said she would check the resident, secure his catheter, and get a cover for the drainage bag. On 1/5/16 at 4:15 pm, the resident was observed propelling his wheelchair in the common TV room. The resident said there was "no problem now" and that tape used to secure the catheter "won't stay on me." On 1/6/16 at 10:35 am, the resident again said tape was used to secure the catheter "but it won't stay." At 10:40 am, LN #7 entered the room and asked the resident if his catheter was secured. The resident pulled up the left leg of his shorts and exposed his catheter tubing which was not secured. Layers of tape were on the tubing and the resident's thigh. The resident said the catheter had not been secured for "months." On 1/6/16 at 12:15 pm, LN #7 said Resident #7's 10/15/15 bladder evaluation was incomplete, there were no other bladder evaluations after that, and the urologist had not re-evaluated the resident. The LN said the catheter change was "past due" and regarding the unsecured catheter, "They've been adding more tape but it's not staying." The LN said the facility did not have "good" catheter holders.	F 315		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident	F 323		

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F 323	<p>Continued From page 20</p> <p>environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure harmful chemicals were securely stored and inaccessible to residents. This was true for all independently mobile, cognitively impaired residents who could access the unsecured chemicals. Failure to safely store harmful chemicals created the potential for residents to experience skin, eyes, respiratory tract and gastric irritation. Findings included: On 1/4/16, between 4:05 pm and 4:45 pm, the following was observed: *One container of bleach wipes on the medication cart table and in the basket by a BP machine left unattended in the 200 Hall. The label read, "Avoid contact with eyes, skin and clothing as this product may produce irritation." *One container of Expo White Board Cleaner observed in the slot near the white board by the nurse station. The label read, "Contact with eyes may cause irritation." On 1/5/16 at 9:10 am, a container of bleach wipes was observed in the basket by the BP machine left unattended in the 200 Hall. At 10:28 am, LN #1 said bleach wipes container were usually locked inside the medication cart and should not be left unattended. At 2:10 am, the DON said the Expo White Board Cleaner bottle should not have been in the slot near the white board and she</p>	F 323	<p>F 323</p> <p>1. How corrective action accomplished for the identified residents? The bleach wipes and white board cleaner were immediately removed and placed in secure area.</p> <p>2. How will you identify other residents with the potential of being affected by the same practice? Residents in the facility have the potential to be affected. Rounds were conducted and no other chemicals were identified unsecured.</p> <p>3. Address what measures will be put in place to ensure deficient practice will not recur. Staff re-educated on proper placement of hazardous products. Re-education done by SDC/ DNS.</p> <p>4. How will the plan be monitored to ensure the solutions are sustained? Audits of common areas for hazardous materials/chemicals or cleaning agents 3 x weekly for 4 weeks, 2 x weekly for 4 weeks, then 1x weekly for 4 weeks. Results will be brought to monthly CQI for review. Audits to be completed by ED/DNS/designee.</p>		

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F 323	Continued From page 21 immediately removed the bottle.	F 323	5. Corrective action will be completed by February 24th, 2016. ED/DNS responsible for compliance.		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, it was determined the facility failed to ensure residents who required and used oxygen had physician's orders for oxygen therapy, received oxygen according to order, and had their oxygen therapy monitored. This was true for 3 of 5 (#s 1, 6 and 10) residents sampled for oxygen and created the potential for harm should residents received oxygen therapy contrary to physician's orders. Finding included: 1. Resident #1 was admitted to the facility on 1/22/15 with multiple diagnoses, including respiratory tract distress. The resident's November and December 2015 Physician's orders, MAR and TAR did not document the resident received oxygen.	F 328	F 328 1. How corrective action accomplished for the identified residents? Resident #1 and #6 have had SATS monitored, oxygen orders verified, TARS accurate, and care plans updated. Resident #10 has been discharged. 2. How will you identify other residents with the potential of being affected by the same practice? Facility wide audit to validate that SATS are monitored, oxygen orders verified, TARS accurate and care plans updated.		

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F 328	<p>Continued From page 22</p> <p>The resident's Respiratory Care Plan documented staff were to administer oxygen as ordered by the MD.</p> <p>On 1/5/16 at 10:00 am, and on 1/6/16 at 12:00 pm, Resident #1 was observed in her room equipped with oxygen at 4 and 3 liters per minute respectively.</p> <p>On 1/6/16 at 12:30 pm, LN #4 said the 2/17/15 physician's order for "Oxygen: 3 liters to keep sats greater than 90%." had not been monitored.</p> <p>2. Resident #6 was admitted to the facility 5/26/15 with multiple diagnoses, including atrial fibrillation and hypertension.</p> <p>The resident's admission and two quarterly MDS assessments, dated 6/2/15, 8/25/15 and 11/18/15 respectively, all coded O2 use. The 11/18/15 MDS also coded moderately impaired cognition with short- and long-term memory impairment.</p> <p>The resident's Respiratory Care Plan, dated 5/31/15 and 9/11/15, documented an ineffective breathing pattern related to anxiety, fear of suffocation, decreased breath sounds, and helplessness. Approaches included O2 as ordered.</p> <p>The resident's January 2016 recapitulated physician's orders included a 5/26/15 order for O2 at 3 L/min per N/C to keep sats above 90 percent "when checked by shift."</p> <p>The resident's TARs for December 2015 and January 2016 included the same orders for O2 and saturation checks, which were scheduled as "Days" and "Nights."</p>	F 328	<p>3. Address what measures will be put in place to validate deficient practice will not recur. Nursing staff re-educated on following physician orders, monitoring SATS, and documenting on MAR/TAR, and updating care plans. During clinical meeting IDT to validate orders, SATS, and care plans are documented on correctly. Re-education to be done by SDC/DNS.</p> <p>4. How will the plan be monitored to ensure the solutions are sustained? Audits of residents requiring oxygen for orders being followed, SATS being documented, care plans updated, and MAR/TAR initialed. Audits will be done 3 x weekly for 4 weeks, then 2 x weekly for 4 weeks, then 1 x weekly for 4 weeks. Audits will be brought to monthly CQI for review. Audits to be completed by ED/DNS/designee.</p> <p>5. Corrective action will be completed by February 24th, 2016. ED/ DNS responsible for compliance.</p>		

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F 328	<p>Continued From page 23</p> <p>The December 2015 TAR documented that O2 at 3 L/min was administered 21 of 31 times on days and 30 of 31 times on nights. It also documented that O2 sats were not checked 9 of 31 times on days and 1 of 31 times on nights.</p> <p>The January 2016 TAR documented the O2 was administered 4 of 5 times on day shift, and that O2 sats were not monitored 1 of 5 times on day shift.</p> <p>The resident's O2 sats were not consistently monitored on the day and night shifts in December and on the day shift in January.</p> <p>On 1/7/16 at 4:30 pm, the DON said the resident's O2 sats were not consistently monitored.</p> <p>3. Resident #10 was readmitted 11/30/15 to the facility with multiple diagnoses, including coronary artery disease and SOB.</p> <p>The resident's 12/4/15 significant change MDS assessment coded intact cognition and O2 use.</p> <p>The resident's Respiratory Care Plan, dated "9/15," documented an ineffective breathing pattern and approaches which included O2 per physician orders.</p> <p>The most recent recapitulated physician's orders in the resident's clinical record was dated December 2015 and included a 9/14/15 order for O2 at 2 L/min per N/C.</p> <p>On 1/7/16 at 7:15 am and 8:00 am, the resident was observed with a NC in place and connected</p>	F 328		

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F 328	Continued From page 24 to a companion O2 tank which was set at flow rate of 3 L/min. On 1/7/16 at 10:05 am, the resident was observed in her room with a NC in place and connected to the O2 companion tank, which was set at 2 L/min. The resident's O2 concentrator was also on and set at 2.5 L/min. LN #8 said the resident was independent changing from the companion tank NC to the concentrator NC. The LN also said the resident did not change the settings on the companion tank or the concentrator, which the resident confirmed. The LN read the liter flow setting on the concentrator as 2.5 L/min. The LN checked the order then said it should be 2 L/min. The LN decreased the concentrator to 2 L/min. On 1/8/16 at 8:15 am, the resident was observed with a NC in place and connected to a companion O2 tank, which was set at 4 L/min. On 1/8/16 at 8:18 am, LN #1 read the L/min setting on the resident's companion O2 tank as 4 L/min. The LN checked the resident's O2 order then said she would change the O2 to 2 L/min.	F 328			
F 329 SS=D	483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.	F 329	F 329 1. How was corrective action accomplished for the identified residents? Residents # 7 and #9 drug regimens have been checked by pharmacist. Behavior monitor form for resident #9 has been changed to reflect more resident specific behaviors. PRN documentation has been reviewed for both residents #7, #9. Resident #7 placed on a 2 week sleep monitor. GDR attempted for resident #9.		

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F 329	Continued From page 25 Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to ensure adequate indication to increase an antipsychotic medication, identify and monitor resident-specific behaviors for the use of psychotropic medications, or consistently monitor the efficacy of PRN pain and antianxiety medications for 2 of 4 residents (#s 7 and 9) reviewed for use of analgesic and psychotropic medications. The deficient practice created the potential for adverse consequences if residents received medications without clinical indication, and monitoring of behaviors and efficacy. Findings included: 1. Resident #7 was admitted to the facility on 10/14/15 with multiple diagnoses, including age-related disability and depression. The resident's January 2016 physician orders	F 329	2. How will you identify other residents with the potential of being affected by the same practice? Residents residing in the facility on an antipsychotic medication have the ability to be affected. These residents behavior sheets have been reviewed and changed if necessary to reflect resident specific behaviors. The MARS have been reviewed for PRN efficacy documentation. 3. Address what measures will be put in place to ensure deficient practice will not recur. The root cause has been determined that non-compliance with this citation is due to inadequate training of licensed nurses addressing documentation and following physician orders. The DNS/SDC/Designee will expand the general orientation of licensed nurses to include, but not be limited to, comprehensive exposure to EmpRes policy and procedures, care plans, following physician orders, and the expectations addressing the standards of practice in the area of documentation. The DNS/SDC/Designee will provide additional training for current licensed nurses to include, but not be limited to, comprehensive exposure to EmpRes policy and procedures, care plans, following physician orders, and the expectations addressing the standards of practice in the area of documentation.		

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F 329	<p>Continued From page 26</p> <p>included Norco every six hours as needed for pain, ordered 10/14/15; Ativan 2 times a day as needed for anxiety, ordered 11/4/15; and Ambien nightly for insomnia, ordered 12/9/15..</p> <p>The resident's December 2015 MAR included the same orders for Norco, Ativan and Ambien. The effectiveness of PRN Norco was not documented for 7 of 21 administrations; the effectiveness of PRN Ativan was not documented for 2 of 4 administrations, and, there was no documentation as to whether the Ambien was effective.</p> <p>On 1/7/16 at 3:15 pm, the DON said the effectiveness of the PRN medications was not consistently monitored. At 3:25 pm, the DON said there should have been a sleep monitor, which she did not find in the resident's record.</p> <p>2. Resident #9 was admitted to the facility 10/1/15 with multiple diagnoses, including schizoaffective disorder and depression.</p> <p>The resident's 10/1/15 admission physician orders included Abilify 2.5 mg daily at bedtime. A 10/30/15 Telephone Order increased the Abilify to 5 mg every day.</p> <p>The resident's care plan for schizoaffective disorder identified hallucinations and delusions as behaviors or symptoms without any resident-specific hallucinations/delusions documented. Interventions included anxiety reducing techniques/activities, a safe environment and effective communication. Monitoring of behaviors was not included in the care plan.</p> <p>Behavior Monitoring Forms for October,</p>	F 329	<p>The DNS/SDC/Designee, approximately two (2) weeks after general orientation of licensed nurses, will conduct additional training in the areas of EmpRes policy and procedures, care plans, following physician orders, and the expectations addressing the standards of practice in the area of documentation.</p> <p>The DNS/SDC/Designee will address the areas of EmpRes policy and procedures, care plans, following physician orders, and the expectations addressing the standards of practice in the area of documentation in the monthly licensed nurse's meeting, assess the need for additional training as supported by the random weekly audits, and provide the training during the meeting.</p> <p>4. How will the plan be monitored to ensure the solutions are sustained? Audits of behavior sheets for documentation, MARS audited for efficacy of PRN medications and Audits of those residents specific behavior sheets, along with those residents using anti- psychotic medication to determine if GDR is warranted, will be done 3 x weekly for 4 weeks, then 2x weekly for 3 weeks, then 1 x weekly for 4 weeks. Audits will be brought to monthly CQI meeting for review. Audits will be completed by DNS/ED/designee.</p>		

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F 329	Continued From page 27 November and December 2015 documented staff were to monitor hallucinations/delusions, lack of interest, and mood changes. Zeros were documented for all of these behaviors on all three shifts every day during all 3 months. Nurses Notes, dated 1/1/15 through 1/7/16, documented the resident was in a "good mood," adjusting to the new surroundings, smiled at times and was able to make his needs known. There was no documentation regarding hallucinations, delusions, mood changes or lack of interest. The LSW documented on 10/5/15 that the resident appeared oriented and made hand signs, "but not known for sure as he cannot answer open ended questions." On 11/3/15, the LSW noted, "...picking wounds...increased Abilify from 2.5 mg to 5 mg." On 11/8/15, the LSW documented, "...picking appears to be [decreased]..." On 1/8/16 at 12:00 pm, the LSW said the Abilify was increased to 5 mg because the resident played with his colostomy bag and its contents and picked at his skin. The LSW said both of those "could be hallucinations." When asked to explain how they may be hallucinations, the LSW said, "We don't know." When asked about the zeros on all of the behavior monitors, the LSW stated, "The nurses were suppose to document and they aren't."	F 329	The DNS/SDC/Designee will conduct random weekly audits for six (6) months evaluating care plans accuracy, following physician orders, and standards of practice addressing documentation compliance. The DNS/SDC/Designee will determine the needs of additional training from communication received during the monthly licensed nurse's meeting and the results of the random weekly audits in the areas of EmpRes policy and procedures, care plans, following physician orders, and the expectations addressing the standards of practice in the area of documentation. The DNS/SDC/Designee will audit MAR's and TAR's in the clinical meeting five (5) times per week to validate that documentation is complete. 5. Corrective action will be completed by February 24th, 2016. ED/ DNS responsible for compliance.	
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH	F 425	F 425 1. How was the corrective action accomplished for the identified residents? Resident #6 has her levothyroxine medication available in the facility. Resident #9 is receiving the correct dose of Abilify and it is in the facility.	

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F 425	<p>Continued From page 28</p> <p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined to facility failed to ensure scheduled medications were available for 2 of 10 sample residents (#s 6 and 9). The failure created the potential for a negative effect when Resident #6's thyroid hormone replacement and Resident #9's antipsychotic medications were not administered as scheduled. Findings included:</p> <p>1. Resident #6 was admitted to the facility on 5/26/15 with multiple diagnoses, including hypothyroidism.</p> <p>The resident's January 2016 physician orders included an order for levothyroxine one time daily,</p>	F 425	<p>2. How you will identify other residents with the potential of being affected by the same practice? Residents in the facility receiving medications have the potential to be affected. A facility wide audit to validate that physician ordered medications are available in the facility.</p> <p>3. Address what measures will be put in place to validate deficient practice will not recur. The root cause has been determined that non-compliance with this citation is due to inadequate training of licensed nurses addressing documentation and following physician orders. The DNS/SDC/Designee will expand the general orientation of licensed nurses to include, but not be limited to, comprehensive exposure to EmpRes policy and procedures, care plans, following physician orders, and the expectations addressing the standards of practice in the area of documentation. The DNS/SDC/Designee will provide additional training for current licensed nurses to include, but not be limited to, comprehensive exposure to EmpRes policy and procedures, care plans, following physician orders, and the expectations addressing the standards of practice in the area of documentation. The DNS/SDC/Designee, approximately two (2) weeks after general orientation of licensed nurses, will conduct additional training,</p>		

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F 425	<p>Continued From page 29 ordered 5/26/15.</p> <p>The resident's December 2015 MAR documented that thyroid medication was administered daily 12/1/15 - 12/29/15 but not administered on 12/30/15 and 12/31/15. PRN Notes on the back of the page documented the thyroid medication was "not available" on 12/30/15. No explanation was documented in the PRN Notes or in Nurse's Notes regarding why the medication was not administered on 12/31/15.</p> <p>On 1/7/16 at 4:30 pm, the DON said the resident's levothyroxine was not available or administered on 12/30/15 and 12/31/15. The DON did not say why the medication was unavailable or what was done about it's unavailability.</p> <p>2. Resident #9 was admitted to the facility 10/1/15 with multiple diagnoses, including schizoaffective disorder.</p> <p>A 10/30/15 Telephone Order increased the resident's Abilify from 2.5 mg every day to 5 mg every day.</p> <p>The resident's October 2015 MAR documented Abilify 5 mg was administered on 10/30 and 10/31/15.</p> <p>The resident's November 2015 MAR did not include the order for Abilify 5 mg. The MAR documented that Abilify 2.5 mg was administered daily from 11/1/15 - 11/28/15 and was not given on 11/29/15 or 11/30/15. PRN Notes on the back of the page documented the Abilify was not available, the pharmacy was notified on 11/29/15 and that "Abilify 2.5 mg - not given - unavailable"</p>	F 425	<p>in the areas of EmpRes policy and procedures, care plans, following physician orders, and the expectations addressing the standards of practice in the area of documentation.</p> <p>The DNS/SDC/Designee will address the areas of EmpRes policy and procedures, care plans, following physician orders, and the expectations addressing the standards of practice in the area of documentation in the monthly licensed nurse's meeting, assess the need for additional training as supported by the random weekly audits, and provide the training during the meeting.</p> <p>4. How will the plan be monitored to ensure the solutions are sustained? DNS/designee to conduct random audits to validate that physician ordered medications are available in the facility. Audits will be done 3x weekly for 4 weeks, then 2 x weekly for 4 weeks, then 1 weekly for 4 weeks. Audits will be reviewed at monthly CQI meeting. ED/DNS/designee to complete the audits.</p> <p>The DNS/SDC/Designee will conduct random weekly audits for six (6) months evaluating care plans accuracy, following physician orders, and standards of practice addressing documentation compliance.</p> <p>The DNS/SDC/Designee will determine the needs of additional training from communication received during the monthly licensed nurse's meeting and the results of the random weekly audits</p>		

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F 425	Continued From page 30 on 11/30/15. On 1/7/16 at 4:45 pm, the DON said Abilify 5 mg was administered to the resident twice in October but the order was not carried over to the November MAR. The DON stated Abilify 2.5 mg continued to be administered until it was not available from the pharmacy on 11/29 and 11/30/15 (refer to F 514).	F 425	in the areas of EmpRes policy and procedures, care plans, following physician orders, and the expectations addressing the standards of practice in the area of documentation. The DNS/SDC/Designee will audit MAR's and TAR's in the clinical meeting five (5) times per week to validate that documentation is complete.		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and	F 431	5. Corrective action will be completed by February 24th, 2016. ED/ DNS responsible for compliance. F 431 1. How was the corrective action accomplished for the identified residents? Resident #18's medications that were in his room were immediately placed in a lock box and he was assessed for self-medication administration. The medication for Resident #2 that was expired was obtained from the pharmacy and the pyxis restocked. 2. How you will identify other residents with the potential of being affected by the same practice? All residents in the facility have the potential to be affected. A facility wide audit to validate that no other unsecured medications were found in resident room. The pyxis system was reviewed by an Omnicare Pharmacist for expired medications. Medications are all current. Residents self-administering medications will have a lock box in their room to secure those		

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F 431	<p>Continued From page 31</p> <p>Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure medications were securely stored in Random Resident #18's room and not accessible to residents, and expired medications were not available for administration to residents. This failed practice created the potential to cause harm for wandering or confused residents from the improperly store medications, and decreased efficacy for any resident receiving the expired medication. Findings included:</p> <p>On 1/5/16 at 9:10 am during the medication pass observation for Resident #2, a label for Oxycodone 10 mg ER documented an expiration date of 8/30/15. LN #1 said the medication should have been destroyed.</p> <p>At 9:25 am, LN#1 opened the Pyxis and found 2 Oxycodone 10 mg ER tablets with expiration dates of, 8/30/15 and 12/8/15. LN #1 said the expired medications should not be stored in the medication room and should be destroyed.</p> <p>2. On 1/7/16 at 8:30 am, the following were observed inside Random Resident #18's room: *A tube of Preparation-H cream *Fluticasone propionate nasal spray *A bottle of Advil 200 mg</p>	F 431	<p>3. Address what measures will be put in place to validate deficient practice will not recur. Monthly audits of pyxis system by RCM for expired medications. Nurses re-educated to check medications for expiration dates before giving. Staff re-education to remove medications immediately and notify RCM, SDC, DNS. Re-education to be completed by SDC/DNS.</p> <p>4. How will the plan be monitored to ensure the solutions are sustained? DNS/designee to conduct facility wide audits during their ECR rounds, of resident rooms for unsecured medications, and medication carts audited for expired medications, will be done 3x weekly for 4 weeks, then 2x weekly for 4 weeks, then 1 x weekly for 4 weeks. Audits will be completed by ED/DNS/designee. Audit of pyxis monthly for expired medications by the RCM.</p> <p>5. Corrective action will be completed by February 24th, 2016. ED/ DNS responsible for compliance.</p>		

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F 431	Continued From page 32 *A bottle of Melatonin 3 mg *A Pro-Air inhaler	F 431			
F 441 SS=D	At 8:45 am, LN #4 said the resident was not assessed to self-administer the drugs safely and the medications should be stored securely. 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.	F 441	F 441 1. How was the corrective action accomplished for the identified residents? Resident #7's foley catheter has been discontinued. 2. How will you identify other residents with the potential of being affected by the same practice? Residents in the facility with a foley catheter have potential to be affected. Those residents with a foley have been assessed for privacy bags and that their tubing is not dragging on the floor.		

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F 441	<p>Continued From page 33</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure indwelling urinary catheter tubing and bags were not in contact with the floor for 1 of 4 residents (# 7) reviewed for urinary catheters. The failure created the potential for the residents to develop infections. Findings included:</p> <p>1. Resident #7 was admitted to the facility on 10/14/15 with multiple diagnoses including urinary retention.</p> <p>On 1/5/16 from 12:05 pm to 12:42 pm, the resident was observed at a table in the main dining room with his urinary catheter drainage tubing in contact with the floor under his wheelchair. At 12:42 pm, the MRM, who identified herself as an LN, was informed the resident's urinary tubing was on the floor. The MRM instructed CNA #9 to put the tubing into the privacy bag under the resident's w/c, which the CNA did.</p> <p>On 1/5/16 at 2:50 pm, the resident was observed lying on his bed with his uncovered urinary drainage bag on the floor next to the bed. The drainage bag was not in a privacy bag/cover or on any kind of a barrier. No staff were in the resident's room at the time.</p>	F 441	<p>3. Address what measures will be put in place to ensure deficient practice will not recur. The root cause has been determined that non-compliance with this citation is due to a lack of proper observation and awareness of staff addressing the appropriate privacy protection of a catheter bag and validate the tubing does not make contact with the floor.</p> <p>The DNS/SDC/Designee will add information on the "CNA Assignment Sheets" for each resident with a foley catheter stating the expectation is the catheter bag is placed in a privacy cover and the catheter tubing is not making contact with the floor.</p> <p>4. How will the plan be monitored to ensure the solutions are sustained? DNS/designee to conduct a facility wide audit, during ECR rounds of residents with a foley catheter will be done 3x weekly for 4 weeks, then 2x weekly for 4 weeks, then 1 x weekly for 4 weeks for privacy bag in place and tubing not dragging on the floor. ED/DNS/designee to do audits.</p> <p>The DNS/SDC/Designee will conduct random weekly audits for six (6) months to confirm the catheter bag is placed in a privacy cover and the catheter tubing is not making contact with the floor.</p>		

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F 441	Continued From page 34	F 441	5. Corrective action will be completed by February 24th, 2016. ED/DNS responsible for compliance.		
F 514 SS=E	<p>On 1/5/16 at 2:53 pm, LN #1 said she would remove the resident's drainage bag from the floor and cover the bag.</p> <p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to maintain clinical records for each resident were complete and accurate. This was true for 4 of 13 (#s 1, 2, 6, and 9) sampled residents. This deficient practice created the potential for decisions to be based on incomplete or inaccurate information which increased the risk for complications due to inappropriate interventions. Findings included:</p> <p>1. Resident #1 was admitted to the facility on 1/22/15 with multiple diagnoses, including respiratory tract distress.</p>	F 514	<p>F 514</p> <p>1. How was the corrective action accomplished for the identified residents? Resident #1 oxygen is being administered per physician orders. MAR/TAR reflect physician orders. Resident #1 is on Hospice and meal monitoring is no longer in effect per hospice orders. Resident #2 physician orders to receive the Boost on non-dialysis days. Her pressure ulcer is resolved. Resident #9 is currently receiving Abilify as ordered. Resident # 6 documentation of PM snack as ordered.</p>		

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F 514	<p>Continued From page 35</p> <p>The resident's Respiratory Care Plan documented staff were to administer oxygen as ordered by the MD.</p> <p>The resident's November and December 2015 physician's orders, MAR, and TAR did not document the resident used oxygen.</p> <p>On 1/5/16 at 10:00 am, and at 1/6/16 at 12:00 pm, Resident #1 was observed in her room equipped with oxygen at 4 and 3 liters per minute respectively.</p> <p>On 1/6/16 at 12:30 pm, LN #4 when shown the 2/17/15 physician's order for "Oxygen: 3 liters to keep sats greater than 90%", "said there was no order for the oxygen to be discontinued and it should have been included in the recapitulated November and December physician's orders.</p> <p>b. Resident #1's Meal Monitor Flowsheet required staff to document the percentage of meal the resident consumed for breakfast, lunch and dinner, and for staff to offer an alternate meal if the resident consumed 50% or less of any meal.</p> <p>The resident's November 2015 Meal Monitor Flowsheet documented the following: The resident consumed 50% or less of her breakfast 9 of 30 times and was offered an alternate meal six of those times.</p> <p>The resident consumed 50% or less of her lunch 17 of 30 times and was offered an alternate meal 5 of those times.</p> <p>The resident consumed 50% or less of her dinner 17 of 30 times and was offered an alternate meal 5 of those times.</p>	F 514	<p>2. How will you identify other residents with the potential of being affected by the same practice? DNS/designee to conduct facility wide audit to validate: 1.) MAR/TAR documents resident use of oxygen. 2.) Physician orders are correctly transferred during the recap process. 3.) Residents eating less than 50% have documentation of alternate meal offered. 4.) Documentation to support the offering of PM snack.</p> <p>3. Address what measures will be put in place to ensure deficient practice will not recur. The root cause has been determined that non-compliance with this citation is due to inadequate training of licensed nurses addressing documentation and following physician orders.</p> <p>The DNS/SDC/Designee will expand the general orientation of licensed nurses to include, but not be limited to, comprehensive exposure to EmpRes policy and procedures, care plans, following physician orders, and the expectations addressing the standards of practice in the area of documentation. The DNS/SDC/Designee will provide additional training for current licensed nurses to include, but not be limited to, comprehensive exposure to EmpRes policy and procedures, care plans, following physician orders, and the expectations addressing the standards of practice in the area of documentation.</p>		

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F 514	<p>Continued From page 36</p> <p>The resident's 2015 December Meal Monitor Flowsheet documented the following: The resident consumed 50% or less of her breakfast 8 of 31 times and was offered an alternate meal 2 of those times.</p> <p>The resident consumed 50% or less of her lunch 9 of 31 times and was offered an alternate meal 4 of those times.</p> <p>The resident consumed 50% or less of her dinner 13 of 31 times and was offered an alternate meal 3 of those times.</p> <p>On 1/7/16 at 11:05 am, LN #4 said the documentation was incomplete, Nurses should offer the alternate meal when the resident ate 50% or less of her meal consumption/alternates, and should be documented.</p> <p>2. Resident #2 was admitted to the facility on 5/16/15. The resident had several admissions and discharges from the facility and was most recently readmitted on 12/31/15 with multiple diagnoses, including osteomyelitis and hypertensive chronic kidney disease. Resident #2 went to dialysis every Monday, Wednesday and Friday.</p> <p>Resident #2's December 2015 Physician's Orders and TAR documented the resident to receive Strawberry Boost every Tuesday, Thursday, Saturday and Sunday and staff were to record cc's consumed.</p> <p>The December 2015 TAR documented the resident received the Strawberry Boost 12 of 18 days from the facility.</p>	F 514	<p>The DNS/SDC/Designee, approximately two (2) weeks after general orientation of licensed nurses, will conduct additional training in the areas of EmpRes policy and procedures, care plans, following physician orders, and the expectations addressing the standards of practice in the area of documentation.</p> <p>The DNS/SDC/Designee will address the areas of EmpRes policy and procedures, care plans, following physician orders, and the expectations addressing the standards of practice in the area of documentation in the monthly licensed nurse's meeting, assess the need for additional training as supported by the random weekly audits, and provide the training during the meeting.</p>	

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

PRINTED: 01/26/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135138	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/11/2016
NAME OF PROVIDER OR SUPPLIER TETON POST ACUTE CARE & REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 3111 CHANNING WAY IDAHO FALLS, ID 83404		
(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 514	<p>Continued From page 37</p> <p>On 1/5/16 at 9:32 am, the resident said she received the Strawberry Boost from the facility and asked for them whenever the nurses forgot to give it to her.</p> <p>On 1/7/16 at 11:05 am, the DON said "the nurses should be giving it Tuesday, Thursday, Saturday, and Sunday and it should be documented."</p> <p>b. Resident #2's December Telephone 2015 Physician's Orders documented a new order for wound care for the resident's buttocks QD and PRN.</p> <p>The resident's 2015 December TAR did not include the new wound order.</p> <p>Resident #2's Weekly Skin Evaluation documented wound assessment were completed on 12/14/15 and 12/21/15. No further skin assessment were performed for December 2015.</p> <p>On 1/6/16 at 11:35 am, the DON said she could not find documentation in the resident's clinical record regarding the 12/24 /15and 12/31/15 wound assessments. The DON had a Weekly Skin report for all residents which she used as a tracking tool, but the information was not part of any resident's clinical record.</p> <p>3. Resident #9 was admitted to the facility 10/1/15 with multiple diagnoses, including schizoaffactive disorder.</p> <p>A 10/30/15 Telephone Order increased the resident's Abilify from 2.5 mg every day to 5 mg every day.</p>	F 514	<p>4. How will the plan be monitored to ensure the solutions are sustained? Facility wide audits to validate the following: MAR/TAR documentation of residents use of oxygen, physician orders are correctly transferred during the recap process, and documentation of the offering of the PM snack. Audits will be done 3x weekly for 4 weeks, 2 x weekly for 4 weeks ,then 1x weekly for 4 weeks. Nutrition/Hydration/skin meeting will audit meal monitor for alternate meals offered if resident eats less than 50%. Facility Audits will be completed by the ED/DNS/designee.</p> <p>The DNS/SDC/Designee will conduct random weekly audits for six (6) months evaluating care plans accuracy, following physician orders, and standards of practice addressing documentation compliance.</p> <p>The DNS/SDC/Designee will determine the needs of additional training from communication received during the monthly licensed nurse's meeting and the results of the random weekly audits in the areas of EmpRes policy and procedures, care plans, following physician orders, and the expectations addressing the standards of practice in the area of documentation.</p> <p>The DNS/SDC/Designee will audit MAR's and TAR's in the clinical meeting five (5) times per week to validate that documentation is complete.</p>	

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

PRINTED: 01/26/2016
FORM APPROVED
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135138	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/11/2016
NAME OF PROVIDER OR SUPPLIER TETON POST ACUTE CARE & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 3111 CHANNING WAY IDAHO FALLS, ID 83404		
(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 514	<p>Continued From page 38</p> <p>The resident's November 2015 MAR included the order for Abilify 2.5 mg, but not the order for Abilify 5 mg. The MAR documented that Abilify 2.5 mg was administered daily from 11/1/15 - 11/28/15. PRN Notes on the back of the page documented, "Abilify 2.5 mg - not given - unavailable" on 11/30/15.</p> <p>On 1/7/16 at 4:45 pm, the DON said the nurse failed to add the order for Abilify 5 mg to the recapitulated physician orders for November 2015.</p> <p>4. Resident #6 was admitted to the facility on 5/26/15 with multiple diagnoses, including nutritional deficiency.</p> <p>The resident's January 2016 physician orders and nutrition/hydration care plan included a pm snack, started 6/3/15.</p> <p>The resident's December 2015 and January 2016 Treatments - Nutrition and Hydration records contained the PM snack and documentation that the snack was not provided 28 of 31 times in December and 3 of 4 times in January.</p> <p>On 1/7/16 at 4:30 pm, the DON said there were multiple "holes" in the documentation. The DON said staff were suppose to document accept and the percent consumed or refused.</p>	F 514	<p>5. Corrective action will be completed by February 24th, 2016. ED/ DNS responsible for compliance.</p>		



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

TAMARA PRISOCK—ADMINISTRATOR
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February 23, 2016

Joshua Bowman, Administrator
Teton Post Acute Care & Rehabilitation
3111 Channing Way
Idaho Falls, ID 83404-7534

Provider #: 135138

Dear Mr. Bowman:

On **January 11, 2016**, an unannounced on-site complaint survey was conducted at Teton Post Acute Care & Rehabilitation. The complaint was investigated in conjunction with the facility's Federal Recertification and Complaint Investigation survey conducted January 4, 2016 to January 8, 2016.

Eleven residents were observed for quality of life and quality of care issues. Residents were observed for accommodation of needs, including toileting, as ordered. Nineteen residents' bedrooms and bathrooms were observed for sanitary conditions and cleanliness. Three residents with TED (Thrombo Embolic Deterrent) socks were observed for proper application and fit as ordered. The oxygen tanks of four residents were observed to ensure they were full and turned on to the proper liter flow. Call lights were also observed throughout to ensure timely accommodation to residents' needs. The nurse's station was observed during the initial tour and throughout the survey for old food trays cluttering the area. Three different licensed nurses were observed during the medication pass task for proper use of the glucometer (blood glucose check machine).

Ten residents were interviewed in a group interview with surveyors, three residents were interviewed individually, and two family interviews were completed regarding quality of life and quality of care concerns. During these interviews, questions were asked regarding a variety of quality of life and quality of care issues, including if the facility was clean and sanitary, accommodation of needs including toileting, TED socks being applied as ordered, comfort of the mattresses, and pain management.

The identified resident's medical record was reviewed, and included October 2015 care plan, Medication Administration Record, Treatment Administration Record, physician orders, nurse's notes,

physician notes, admission assessment, activities of daily living record, and vital sign record. Incident and Accident reports and Grievances for October 2015 were also reviewed.

The complaint allegations or entity-reported incidents, findings and conclusions are as follows:

Complaint #ID00007177

Allegation #1:

The complainant reported the resident was left in a wheelchair for two hours after becoming incontinent.

Findings:

During the survey, residents were changed after incontinence in a timely manner and toileted when needed. Nine of ten residents in the group interview and three of three resident interviewed individually stated they were able to get help when needed, in a timely manner, and had no concerns with getting cleaned up after incontinence. Review of the identified resident's medical record documented the resident was on a check and change program every two hours and as needed. It documented the resident was continent of bowel and bladder, and on October 15, 2015 the resident was continent of bowel and bladder across all shifts.

Based on observations, record review, and interviews, the allegation was unsubstantiated due to lack of evidence.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

Allegation #2:

The complainant reported the identified resident's bathroom was not clean and unsanitary.

Findings:

During initial tour of the facility and throughout the survey, nineteen residents' bedrooms and bathrooms were observed clean and sanitary. During the group interview, ten of ten residents thought the facility was clean and sanitary.

Based on observations and interviews, the allegation was unsubstantiated due to lack of evidence.

Joshua Bowman, Administrator
February 23, 2016
Page 3 of 6

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

Allegation #3:

The complainant reported on October 15, 2015 the resident's TED (Thrombo Embolic Deterrent) socks were causing extreme pain and cutting into his legs and feet; on October 16, 2015 the TED socks were not applied to the resident as ordered.

Findings:

Three residents were observed with TED socks on, and were applied per physician order and fit properly. Five residents with TED socks in the group interview and four residents in individual interviews stated their TED socks were always applied as ordered, fit properly, and did not cause them pain. The identified resident's Treatment Administration Record documented the resident's TED socks were applied as ordered on October 15, 2015 and October 16, 2015 during the day shifts.

Based on observations, interviews, and record review, the allegation was unsubstantiated due to lack of evidence.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

Allegation #4:

The complainant reported the resident's feeding and oxygen machines were turned off from 9:30 pm on October 15, 2015 to 6:39 am on October 16, 2015.

Findings:

Four residents with oxygen tanks were observed during the survey, and tanks were full and flowing with the correct liters of oxygen. The identified resident's October 2015 Treatment Administration Record documented the resident's tube feeding was running on the night shift October 15, 2015 and day shift October 16, 2015. The Treatment Administration Record also documented oxygen was applied and running as ordered during the identified times. A October 16, 2015 nurse note at 6:00 am documented "last night" the tube feeding was held due to nausea. Physician orders documented the physician was notified and nausea medication was ordered.

Based on observation and record review, the allegation was unsubstantiated due to lack of evidence.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

Allegation #5:

The complainant reported on October 16, 2015 the resident waited an hour and twenty minutes for assistance after pressing his call button.

Findings:

Throughout the survey, residents' call lights were answered by staff in a timely manner. Nine of ten residents in the group interview and three of three resident interviewed individually had no issues with getting their needs met in a timely manner. October 2015 grievances were reviewed and documented no concerns with call light waiting times.

Based on observations, interviews, and record review, the allegation was unsubstantiated due to lack of evidence.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

Allegation #6:

The complainant reported the nurse's station was cluttered with old food trays.

The nurse's station was clear of food trays and appeared clean and organized throughout the survey. No October 2015 grievances documented concerns of cleanliness for the nurse's station.

Based on observations, record review, and interviews, the allegation was unsubstantiated due to lack of evidence.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

Allegation #7:

The complainant reported the resident was sleep deprived because of a rod sticking through the resident's thin mattress.

Findings:

Six residents interviewed individually stated their mattresses were comfortable and did not interfere with sleep. No grievances in October 2015 documented a concern with thin mattresses. The identified resident's medical record did not document concerns with sleep.

Based on interviews and record review, the allegation was unsubstantiated due to lack of evidence.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

Allegation #8:

The complainant reported the person who checked the resident's blood sugar did not know how to operate the machine.

Findings #8:

Three different licensed nurses were observed performing blood glucose checks, and performed the task according to proper procedures and standards of practice. No October 2015 grievances documented concerns with blood glucose checks.

Based on observations and record review, the allegation was unsubstantiated due to lack of evidence.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

Allegation #9:

The complainant reported on October 16, 2015 the resident had a headache and did not receive pain medication for more than an hour.

Findings #9:

Ten of ten residents in the group interview stated they had good pain control and were able to get treatment for pain in a timely manner. The resident's Medication Administration Record documented the resident received Tylenol for a headache on October 16, 2015, with good results. No grievances documented concerns with pain management in October of 2015.

Based on interviews and record review, the allegation was unsubstantiated due to lack of evidence.

Joshua Bowman, Administrator
February 23, 2016
Page 6 of 6

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

Allegation #10:

The complainant reported the resident's blood pressure was extremely high.

Findings #10:

The identified resident's Medication Administration Record (MAR) documented the resident received two different blood pressure medications, including one medication, Labetolol, as needed for a systolic blood pressure rising above 160 mmHg. The MAR documented the resident's blood pressure was measured every day and were within ordered parameters, below 160 mmHg.

Based on record review, the allegation was unsubstantiated due to lack of evidence.

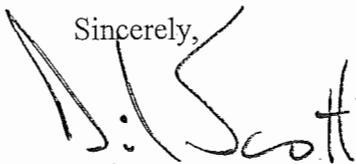
CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

Unsubstantiated. Referral to the appropriate agency.

As none of the allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

A handwritten signature in black ink that reads "D. Scott". The signature is written in a cursive style with a large, sweeping initial "D" and a stylized "S".

David Scott, R.N., Supervisor
Long Term Care

DS/lj



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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February 8, 2016

Joshua Bowman, Administrator
Teton Post Acute Care & Rehabilitation
3111 Channing Way
Idaho Falls, ID 83404-7534

Provider #: 135138

Dear Mr. Bowman:

On **January 11, 2016**, an unannounced on-site complaint survey was conducted at Teton Post Acute Care & Rehabilitation. The complaint was investigated in conjunction with the facility's on-site Recertification and State Licensure survey conducted from January 4 to January 11, 2016. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007070

Allegation #1:

An identified resident was losing weight and the nursing staff were not weighing the resident daily as ordered.

Findings:

The identified resident and one other resident's medical record were reviewed for weight concerns and there were no issues. The identified resident was weighed as ordered by the physician except on days the resident refused.

Based on record review this allegation could not be substantiated.

Joshua Bowman, Administrator
February 8, 2016
Page 2 of 3

Conclusions:

Unsubstantiated. Lack of sufficient evidence.

Allegation #2:

An identified resident had a break on the skin on his forehead due to fall in June for which the nursing staff were not providing appropriate care. .

Findings #2:

The medical record of the identified resident was reviewed for quality of care concerns. The Incident and Accident reports for June to July 2015 were reviewed. Two nursing staff were interviewed regarding the facility procedure of notification for residents who had a fall.

Two Nursing staff were observed as they performed wound dressing to two residents, and the residents were interviewed about quality of care and quality of life concerns.

The resident's clinical record documented the wound was cleaned with normal saline and gauze, but the resident sometimes refused the dressing changes and at times would not allow nursing staff to enter his room to provide nursing cares.

Residents interviewed for wound care said their wounds were dressed as ordered; with none of the residents complained of not receiving appropriate care.

The Incident and Accident report documented the responsible party was notified when there was a change in condition with the residents.

The Director of Nursing said the reporting party was informed of the resident's fall but the reporting party said she already knew about it. The DON said the reporting party visited the identified resident almost every day and sometimes twice a day.

Based on interview and record review this allegation could not be substantiated.

Conclusions:

Unsubstantiated. Lack of sufficient evidence.

Allegation #3:

The reporting party stated the identified resident was taken off his/her anti-depressant medications and subsequently tried to hurt himself/herself.

Joshua Bowman, Administrator
February 8, 2016
Page 3 of 3

Findings #3:

The Medical Administration Record, nurse's notes, Social Worker's Notes, physician's orders, and physician's notes were reviewed.

The identified resident's medical record documented the resident refused to take all of his medication other than his pain and bowel medications. The resident was educated by the nursing staff, Social Worker, and by his physician regarding the need to take his medications, but the resident continued to refuse.

On June 26, 2015 the physician discontinued all of the resident's medications due to his refusal to take any except pain and bowel medications. The resident had not taken his medications since June 6, 2015 up to the date he was transferred to the hospital.

Based on record review, this allegation was unsubstantiated due to lack of sufficient evidence.

Conclusions:

Unsubstantiated. Lack of sufficient evidence.

None of the allegations were substantiated. Therefore, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

A handwritten signature in cursive script, appearing to read "Nina Sanderson".

Nina Sanderson, LSW, Supervisor
Long Term Care

NS/lj



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
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March 11, 2016

Joshua Bowman, Administrator
Teton Post Acute Care & Rehabilitation
3111 Channing Way
Idaho Falls, ID 83404-7534

Provider #: 135138

Dear Mr. Bowman:

On **January 11, 2016**, an unannounced on-site complaint survey was conducted at Teton Post Acute Care & Rehabilitation. The complaint was investigated in conjunction with the on-site Federal Recertification and Complaint Investigation and State Licensure survey conducted January 4, 2016 to January 8, 2016.

Ten residents were observed for quality of life, quality of care issues, accommodation of needs, and dignity issues. Three residents with TED (Thrombo Embolic Deterrent) socks were observed for proper application and fit. Four residents with oxygen were observed for the proper liter flow rate and the amount of oxygen in their tanks. Five licensed nurses were observed as they passed medications. And, staffs' responses to call lights were observed throughout the survey.

Ten residents were interviewed in a Resident Group interview with surveyors, three residents were interviewed individually, and two family interviews were completed regarding quality of life and quality of care concerns, including medications, oxygen use, fall prevention, accommodation of needs, and compression stockings. The Director of Nursing Services, five licensed nurses, five Certified Nursing Assistants, two therapy staff, and a Social Worker were also interviewed regarding the same issues.

The clinical records for the identified resident and thirteen other residents were reviewed regarding the various issues. The facility's incident and accident reports, grievance files, investigations of allegations of abuse, and gait belt policy and procedure were also reviewed.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00006925

ALLEGATION #1:

The identified resident was naked from the waist down and "just barely covered with a sheet." The facility said that was the resident's preference.

FINDINGS:

The identified resident's clinical record did not document any issues regarding dignity. The survey team observed for dignity issues throughout the survey and observed ten residents in particular. No dignity issues were identified. The allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

Staff attempted to transfer the identified resident without a gait belt. Staff said "State" does not allow the use of gait belts for transfers. The fall mat was not next to the resident's bed at all times.

FINDINGS 2:

The facility's gait belt policy documented that gait belts would be used for transfers unless contraindicated in the care plan. The use of a gait belt was not contraindicated in the identified resident's care plan. Per interviews with the Director of Nursing Services and Certified Nursing Assistants, the gait belt policy was current and in effect.

During the survey, three residents were observed during transfers and the staff used a gait belt each time. In addition, the fall mats were in place for three residents with orders and/or care plans for fall mats.

The allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The identified resident's right ankle was red and swollen with a "sore" and the leg was not elevated. Heel protectors and wound care were not provided as ordered. The resident developed foot drop due to

improper heel floating.

FINDINGS #3:

Review of the identified resident's clinical record and staff interviews revealed the right ankle was red and swollen and there was a sore on the ankle on admission. The record documented there was significant edema in both feet/heels and that reddened areas on the left foot were also present on admission. Pressure relief interventions, including floating the heels, were implemented at that time. The record documented the resident's feet were frequently off the bed and that staff repositioned them often. The edema persisted and five days after admission, new reddened areas developed on the right ankle/heel and the pressure reduction mattress was changed to a low air-loss mattress. The next day, cellulitis in the right ankle/foot was diagnosed. Protective boots were added and the cellulitis was treated with two antibiotics. The cellulitis resolved slowly but not before the ankle and heel sores worsened and the resident was referred to a wound clinic for specialized treatment. The record documented that wound care was provided as ordered.

Wound care orders were not followed for one of five other residents reviewed for pressure ulcers. However, the heels of those residents were properly floated and/or in protective boots as ordered. Foot drop was not observed or identified for any of the residents.

The allegation was substantiated regarding the identified resident's red and swollen ankle with a sore and related to another resident's inconsistent wound care. The deficient practice was cited at F 314.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #4:

The identified resident's leg brace was not on and the physician's orders for a smaller brace were not followed.

FINDINGS:

Review of the identified resident's clinical record and staff interviews revealed the resident was confused at times and frequently "dismantled" and removed the right knee brace. The physician changed the orders to a hinged brace when out of bed and a knee immobilizer when in bed, which the resident more readily tolerated. On Friday, February 20, 2015, the physician ordered "re-consult" by a limb/brace company to fit and apply a hinged brace with specific settings. On February 23, 2015, the limb/brace company evaluated the resident's brace, replaced a pad, and adjusted the brace to the new settings.

One resident with a brace was observed and interviewed during the survey. The resident denied issues with the brace and none were identified regarding the brace. The allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #5:

The identified resident's "tray" with water, Ensure supplement, and telephone were not within reach and the resident was left without fluids for long periods of time.

FINDINGS:

The facility's investigation of neglect documented the identified resident's over-bed table with his/her personal items was not always accessible. In addition, during the survey, a resident was observed with their drinking liquids not accessible during a meal. The allegation was substantiated and the deficient practice was cited at F 246.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #6:

The facility did not notify the identified resident's family for three hours after a fall.

FINDINGS:

The facility's fall investigation report and the clinical record documented the identified resident was not injured after a fall on March 3, 2015 at 8:30 pm. However, two hours after the fall, the resident complained of leg pain and was medicated for the pain. The pain did not resolve and the physician was notified. The physician instructed the facility to send the resident to an emergency room for evaluation. The resident's family member was notified at 11:30 pm., three hours after the fall. Deficient practice was not identified as the facility acted appropriately. The allegation was substantiated, but not cited.

CONCLUSIONS:

Substantiated. No deficiencies related to the allegation are cited.

ALLEGATION #7:

The identified resident's Ativan was not continued from home despite assurances during the admission

care conference that it would be. The resident was over-medicated and was left slumped over on a dining room table due to excessive Ativan.

FINDINGS:

The clinical record documented Ativan was not included in the identified resident's admission orders and that resumption of Ativan was not discussed during three care conferences with family members. On March 4, 2015, the resident experienced leg pain and was medicated with Tylenol with Codeine. The resident became anxious when the pain was not relieved after forty minutes. The physician was notified and he/she ordered a one-time dose of Ativan two milligrams, with good results noted one hour after it was administered. The next day, the physician ordered Ativan half a milligram every four hours as needed for anxiety. Ativan half a milligram was administered once on March 6 2015 and once on March 7, 2015 without side effects or adverse reactions noted.

During the survey, the clinical records of four residents identified to have pain and one resident with an anti-anxiety medication were reviewed. The residents were also observed in their rooms and in dining rooms. None of the residents were over-medicated.

The allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #8:

The identified resident's oxygen tank was empty and the oxygen was not provided as ordered.

FINDINGS:

The identified resident's clinical record documented that oxygen was administered at two liters per minute as ordered. During the survey however, it was determined that oxygen was not provided as ordered for three residents. The deficient practice was cited at F 328.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #9:

The identified resident experienced increased confusion due to lack of care.

FINDINGS:

The clinical record documented the identified resident was confused on admission and the confusion fluctuated from "pleasantly confused" to "very confused " throughout the resident's stay in the facility. The resident also experienced agitation at times. There was no documented evidence the resident's confusion was related to lack of care. The allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #10:

The identified resident was not toileted every two hours according to care plan and experienced bowel incontinence as a result. The resident's commode height was set too high and it was uncomfortable.

FINDINGS #10:

The clinical record documented the identified resident was toileted every two hours as care planned and there was no evidence the resident's toilet or bedside commode chair was too high or uncomfortable.

Review of the facility's grievance files revealed there were no concerns or complaints about the lack of assistance with toileting or the height or comfort of toilets or bedside commode chairs.

Three individual residents and ten residents in a Resident Group were interviewed. None of the residents expressed concerns about toileting assistance or the height and comfort of toilets or bedside commode chairs.

The allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #11:

The discharge summary, medication reconciliation, "etcetera," was not included when the identified resident was transferred to another facility.

FINDINGS #11:

The clinical record documented the history and physical by the physician and the medication records were faxed to the other facility two weeks prior to the identified resident's transfer to that facility.

Physician, therapy, and nursing progress notes and laboratory reports were also faxed to the other facility eight days before the transfer. Deficient practice was not identified and the allegation was not substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #12:

A "pressure sock" caused a "tourniquet effect" and restricted "venous return" when it was applied to the identified resident's left lower leg, which was edematous. Also, a tourniquet was left on the resident's arm when a nurse left the room to obtain a second blood draw syringe.

FINDINGS #12:

The identified resident's clinical record documented that compression stockings were applied as ordered to manage lower extremity edema and that blood was drawn twice by facility staff for laboratory testing. There was no documented evidence in the resident's record or the facility's grievance files that compression stockings caused a tourniquet effect or that tourniquets were left in place too long.

Three individual residents and ten residents in a Resident Group were interviewed. The residents said that tourniquets were not left on too long when blood was drawn and none of the residents expressed concerns regarding how compression stockings were applied.

The allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #13:

Physical therapy and occupation therapy was not provided when the identified resident was "not arousable."

FINDINGS:

The identified resident's clinical record documented that physical therapy and occupational therapy were both rescheduled when the resident was sleeping or unable to participate.

Joshua Bowman, Administrator
March 11, 2016
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The clinical records of three other residents who received specialized rehabilitation services were reviewed, the family member of one of those residents was interviewed, and the facility's grievance files were reviewed. Deficient practice regarding specialized rehabilitation services was not identified.

The allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

Based on the findings of the investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this findings letter, as it will be addressed in the provider's Plan of Correction.

If you have questions, comments or concerns regarding our investigation, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

A handwritten signature in black ink that reads "D. Scott". The signature is written in a cursive style with a large, sweeping initial "D" and a clear "Scott" following.

David Scott, R.N., Supervisor
Long Term Care

DS/lj



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
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March 11, 2016

Joshua Bowman, Administrator
Teton Post Acute Care & Rehabilitation
3111 Channing Way
Idaho Falls, ID 83404-7534

Provider #: 135138

Dear Mr. Bowman:

On **January 11, 2016**, an unannounced on-site complaint survey was conducted at Teton Post Acute Care & Rehabilitation. The complaint was investigated in conjunction with the on-site Federal Recertification and Complaint Investigation and State Licensure survey conducted January 4, 2016 to January 8, 2016.

Ten residents were observed for quality of life, quality of care issues, accommodation of needs, and dignity issues. Five licensed nurses were observed as they passed medications. Staff responses to call lights were observed throughout the survey.

Ten residents were interviewed in a Resident Group interview with surveyors, three residents were interviewed individually, and two family interviews were completed regarding quality of life and quality of care concerns, including medications, accommodation of needs. The Director of Nursing Services, five licensed nurses, five Certified Nursing Assistants, two therapy staff, and a Social Worker were also interviewed regarding the same issues.

The clinical records for the identified resident and thirteen other residents were reviewed regarding the various issues. The facility's incident and accident reports, grievance files, and abuse allegation investigations, were also reviewed.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007135

ALLEGATION #1:

The resident did not receive any medications, including pain medications, for twenty-four hours after admission. Oxycodone was to be given every three hours at the patient's request. On several occasions, the resident had to request the Oxycodone a second time and it was at least an hour late.

FINDINGS:

The clinical record documented the identified resident was admitted to the facility at 6:00 pm on July 30, 2015, and that ten medications were administered at 8:00 pm the same day. Oxycodone was discontinued by the hospital when the resident was transferred to the facility. The facility notified the physician of the resident's pain. The physician ordered Oxycodone every three hours as needed for pain the next morning. The resident was alert and oriented, able to make his/her needs known, and to request pain medication when needed. Oxycodone was requested and administered twice on July 31, 2015, three times on August 1, 2015, twice on August 2, 2015, four times on August 3, 2015, and twice on August 4, 2015, before the resident left the facility at 11:00 am. There was no documented evidence the resident requested the pain medication every three hours, had to request the medication more than once, or that the medication was an hour late.

During the survey, residents' medications, including pain medications, were observed to be administered on time by licensed nurses. No issues with medications, including pain medications, were identified when the clinical records of other residents, grievance files, and abuse investigations were reviewed. In addition, individual residents, family members, and residents in the Resident Group, did not express concerns about pain medications when interviewed.

Based on the observations, record reviews, and interviews, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The facility did not have complete and accurate medical information regarding the identified resident's bilateral arm fractures and a staff member who was informed of the fractures did not share the information with other staff.

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FINDINGS:

The identified resident's clinical record contained evidence that the hospital did not inform the facility or provide documentation about a right arm "nondisplaced fracture that is otherwise in apparent" when the resident was transferred to the facility. One day after admission, the resident informed the occupational and physical therapy staff of the right arm fracture; however, the claim was not verified until two days later when the facility received the x-ray report.

Though the allegation was substantiated, deficient practice on the facility's part was not identified.

CONCLUSIONS:

Substantiated. No deficiencies related to the allegation are cited.

ALLEGATION #3:

A physical therapist instructed the resident to "pick up" a four point walker without wheels with his/her broken right arm and on August 3, 2015, the resident was told to walk using the walker with two broken arms. The identified resident was not ever moved or walked by facility staff. At one point, the resident was made to sit in a chair, which he/she could not get out of because of broken arms.

FINDINGS:

The clinical record and the facility's abuse investigation documented the identified resident walked with Certified Nursing Assistants and with therapy staff two consecutive days. Therapy records also documented the resident used a hemiwalker with minimal assistance one day, but "refused" the hemiwalker the next day and "wanted to use a 4WW (###)" instead. The resident was educated that it was "too dangerous to try" the four wheeled walker. Additionally, there was no evidence in the resident's clinical record or the facility's grievance files and abuse investigations that the resident was not assisted to get out of a chair or wheelchair.

Based on interviews with other residents and staff and review of other residents' clinical records, there were no concerns about therapy services, mobility, or confinement in a chair. It was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

The identified resident did not receive eating assistance and was left with food that he/she could not cut. One time the resident was told there was no more food and once the food was not replaced when soda pop and water were split on it. The resident was never told a "ticket" was the menu to select the next meal, so he/she was unable to select his/her own meal. In addition, on one night cottage cheese and fruit cocktail was dinner, which was inadequate.

FINDINGS:

The clinical record documented the identified resident was provided assistance with eating as care planned, chose to feed him/herself on two occasions, and consumed eighty-five to one hundred percent of meals. There was no documented evidence the resident's food was not cut when needed, liquids were spilled on food and the food was not replaced, the resident was unable to select his/her meals, or that the resident did not like or want cottage cheese and fruit but it was served anyway.

Review of menus, inspection of the kitchen, and interviews with staff revealed there was an adequate supply of food in the facility and that cottage cheese and fruit was one of the alternate meals. During two meal observations in dining rooms and resident rooms, staff provided eating assistance, including cutting up food, for resident's who needed it, cleaned up two spills and offered to replace the food that got wet, and offered more food to several residents. Several residents said they preferred cottage cheese and fruit to the main meal.

The allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #5:

The resident sat in an adult brief for thirty minutes and layed on urine soaked sheets twice because staff did not change them. The resident smelled of feces at times because he/she was not cleaned well.

FINDINGS:

Based on review of clinical records for the identified resident and five other residents with incontinence, the facility's grievance files and abuse investigations, interviews with residents, families, and staff, and observations of the resident's and their bed linens, it was determined the allegation could not be substantiated.

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CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #6:

The identified resident was not seen by a doctor once in the five days he/she was in the facility.

FINDINGS:

Based on review of the identified resident's clinical record, the allegation was substantiated. However, the resident was evaluated and assessed by two different physicians two and three days prior to transfer to the facility. The State requirement for evaluation and assessment by a health care provider at least five days before or within forty-eight hours after admission to the facility was met. Therefore, deficient practice was not identified or cited.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #7:

The bandages applied at the hospital were not changed or looked at during the identified resident's stay in the facility. A back wound drained onto the resident's sling, but the dressing and the sling were never changed. The arm slings were not applied correctly.

FINDINGS:

The clinical record documented the identified resident's multiple skin injuries were assessed and the dressings were changed on admission, the next day, and four days later as ordered. However, another resident's dressings were not changed as ordered. Therefore, the allegation was substantiated and the deficient practice was cited at F 314.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #8:

The identified resident's toilet, full of feces, was not flushed for three hours. Feces was on the toilet seat and an adult brief full of feces was in the trash can.

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FINDINGS:

Based on the survey team's observations of residents' rooms and bathrooms conducted within minutes of entering the facility on January 4, 2016 and continued throughout the survey, interviews with residents, families, and staff, review of residents' clinical records and the facility's grievance files and abuse investigations, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

Based on the findings of the investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this findings letter, as it will be addressed in the provider's Plan of Correction.

If you have questions, comments or concerns regarding our investigation, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

A handwritten signature in black ink that reads "D. Scott". The signature is written in a cursive style with a large, sweeping initial "D" and a long horizontal stroke for the "S".

David Scott, R.N., Supervisor
Long Term Care

DS/lj