IDAHO DEPARTMENT OF
# HEALTH & WELFARE

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

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

**CERTIFIED MAIL: 7012 3050 0001 2125 6065**

October 10, 2014

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

FILE COPY

Provider #: 135138

Dear Mr. Spiers:

On **September 26, 2014**, a Complaint Investigation survey was conducted at Teton Post Acute Care & Rehabilitation by the Department of Health & Welfare, 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 in your facility to be **WIDESPREAD PATTERN** deficiencies and to constitute immediate jeopardy to residents' health and safety. You were informed of the immediate jeopardy situations in writing on **September 26, 2014.**

On **September 26, 2014**, the facility submitted a credible allegation that the immediate jeopardy was corrected. After review of your Plan of Correction, it was determined that the immediate jeopardy to the residents had been removed. However, the deficiencies as identified on the revised Form CMS-2567 remain and require a Plan of Correction. The most serious deficiency now constitutes actual harm that is not immediate jeopardy and that is isolated in scope, as evidenced by the Form 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, and a similar State Form 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. **Please provide ONLY ONE completion date for each federal and state tag in**

**column X5 Completion Date** to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.

After each deficiency has been answered and dated, the administrator should sign both Statement of Deficiencies and Plan of Correction, Form CMS-2567 and State Form, in the spaces provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **October 23, 2014**. Failure to submit an acceptable PoC by **October 23, 2014**, may result in the imposition of additional civil monetary penalties by **November 12, 2014**.

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

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

  If the facility has not been given an opportunity to correct, the facility must determine the date compliance will be achieved. If CMS has issued a letter giving notice of intent to implement a denial of payment for new Medicare/Medicaid admissions, consider the effective date of the remedy when determining your target date for achieving compliance.
- The administrator must sign and date the first page of both the federal survey report, Form CMS-2567 and the state licensure survey report, State Form.

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

Based on the immediate jeopardy cited during this survey;

**F309 -- S/S: K -- 42 CFR §483.25 -- Provide Care/Services for Highest Well Being**

As noted in the letter of **August 6, 2014**, as a result of our finding that your facility is not in substantial compliance we are recommending to Centers for Medicare & Medicaid Services (CMS) that the

following remedy(ies) be imposed:

**Denial of payment for new admissions effective as soon as notice requirements can be met. [42 CFR §488.417(a)]**

**A 'per instance' civil money penalty of $5000.00.**
*(THIS REMEDY IS GENERALLY RESERVED FOR SITUATIONS OF SERIOUS NONCOMPLIANCE AS DESCRIBED AT §7510)* (§488.430)

The change in the seriousness of the non-compliance on **September 26, 2014,** has resulted in a change in the remedy(ies) we will recommend from those previously mentioned to you in the originating survey letter of **August 6, 2014.**

We must also recommended to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **January 25, 2015**, 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 and Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.**

Your facility's noncompliance with the following:

**F309 -- S/S: K -- 42 CFR §483.25 -- Provide Care/Services for Highest Well Being**

has been determined to constitute substandard quality of care (SQC) as defined at 42 CFR §488.301. Sections 1819 (g)(5)(c) and 1919 (g)(5)(c) of the Social Security Act and 42 CFR §488.325 (h) requires the attending physician of each resident who was found to have received substandard quality of care, as well as the state board responsible for licensing the facility's administrator be notified of the substandard quality of care. In order for us to satisfy these notification requirements, and in accordance with 42 CFR §488.325(g), you are required to provide the following information to this agency within ten (10) working days of your receipt of this letter:

The name and address of the attending physician of each resident found to have received substandard quality of care, as identified below:

Residents **#2 Gerald Richards** as identified on the enclosed Resident Identifier List.

Please note that in accordance with 42 CFR §488.325(g), your failure to provide this information timely will result in termination of participation or imposition of additional remedies.

**STATE ACTIONS** effective with the date of this letter **(October 10, 2014)**:

If you believe the deficiencies have been corrected, you may contact Lorene Kayser, L.S.W., Q.M.R.P. or David Scott, R.N., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0036; phone number: (208) 334-6626; 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.

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

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

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

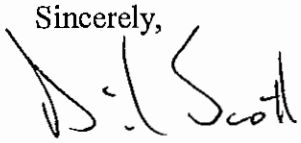
- BFS Letters (06/30/11)

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

This request must be received by **October 23, 2014**. If your request for informal dispute resolution is received after **October 23, 2014**, 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 Lorene Kayser, L.S.W., Q.M.R.P. or David Scott, R.N., Supervisors, Long Term Care at (208) 334-6626.

Sincerely,



DAVID SCOTT, R.N., Supervisor
Long Term Care

DS/dmj
Enclosures

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

PRINTED: 10/10/2014
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 135138 | | C 09/26/2014 |

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 |
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| F 000 | INITIAL COMMENTS<br><br>The following deficiencies were cited during a Complaint survey of your facility.<br><br>The surveyors conducting the survey were: Susan Gollobit , RN, Team Coordinator and Rebecca Thomas, RN<br><br>An IJ (Immediate Jeopardy) was identified at F309 and the facility was notified on 9/26/14 at 12:40 PM. The facility submitted an Immediate Plan of Correction on 9/26/14 at 6:45 PM. On-site verifiction of the plan's implementation was completed on 9/26/14 at 7:30 PM and the Immediate Jeopardy was abated.<br><br>The survey team entered the facility on 9/23/14 and exited on 9/26/14.<br><br>Survey Definitions:<br>ADL = Activities of Daily Living<br>BIMS = Brief Interview for Mental Status<br>cm = Centimeters<br>CNA = Certified Nurse Aide<br>DON = Director of Nursing<br>LN = Licensed Nurse<br>MAR = Medication Administration Record<br>MDS = Minimum Data Set assessment<br>PRN = As Needed | F 000 | DISCLAIMER CLAUSE<br><br>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. | |
| F 309<br>SS=K | 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br><br>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 | F 309 | *F309*<br>• *How corrective action accomplished for the identified residents?*<br><br>LN#3 no longer works at the facility as of 9/28/14.<br><br>On 9/26/14 resident #2 had his blood glucose levels reviewed by the Director of Nursing and or designee, and a HgbA1C lab drawn on 9/28/14, which is to be repeated every three months.<br><br>On 9/26/14, resident #3's blood glucose records were reviewed and updated to reflect the new Diabetic Monitoring policy by the Director of Nursing and or designee, and a HgbA1C lab was drawn on 9/28/14, which is to be repeated every three months. | |

RECEIVED
OCT 23 2014
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE
Administrator 10-22-14

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 309 | Continued From page 1<br>and plan of care.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on facility records, dialysis records, EMS (Emergency Medical Services) records, and facility staff, dialysis center staff, EMS staff, and family interviews, it was determined the facility placed residents in Immediate Jeopardy when it failed to have systems and procedures in place to identify when 1 of 4 sampled residents (#2) experienced a critical hypoglycemic event. This Immediate Jeopardy event, which could have resulted in death, occurred on 9/9/14, when facility staff transported and delivered Resident #2 in an unresponsive state to a nearby dialysis center, where he required emergency treatment by EMS staff for a critically low blood glucose (BG) level. The facility at the time of survey had 13 residents with diabetes mellitus, four of whom were routinely transported by facility van to dialysis appointments. Additionally, 2 of 4 sampled residents (#'s 1 and 3) did not receive blood glucose monitoring as ordered by their physicians. This failed practice placed both Residents #1 and #3 at risk for critical hypo- or hyper-glycemic events. Findings include:<br><br>On 9/26/14 at 12:40 PM, the Administrator and DON were notified the facility had an Immediate Jeopardy situation for the lack of monitoring- and interventions for blood glucose levels which placed the 3 sampled dialysis residents, as well as all diabetic residents in the building, including those also receiving dialysis, in danger that could lead to serious injury or death. | F 309 | On 9/26/14 resident #1's medical record was reviewed by the Director of Nursing and or designee, and an order was received to discontinue TID blood glucose checks. A new order was received to check blood glucose one time weekly in the AM. A HgbAlC lab was drawn on 10-3-14 to be repeated every three months.<br><br>• *How you will identify other residents with the potential of being affected by the same practice?*<br>The facility has stopped admitting diabetic residents until the facility is placed in compliance.<br><br>The facility has updated its policy on blood glucose monitoring protocol on 9/26/14. The revised policy includes: blood glucose physician notification parameters, and guidance for those residents that take oral anti-diabetic medication. | |

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| F 309 | Continued From page 2<br>The facility provided an acceptable abatement plan on 9/26/14 at 6:45 PM, which included no admissions of residents with diabetes mellitus until an acceptable follow up survey was completed, revision of the facility's diabetic policy, updated records to reflect the policy changes, monitored care of dialysis residents, and diabetic/dialysis education to all of the facility nursing staff. On-site verifiction of the plan's implementation was completed on 9/26/14 at 7:30 PM and the Immediate Jeopardy was abated.<br><br>1. Resident # 2 was admitted to the facility on 9/3/14 with diagnoses that included muscle weakness, Rhabdomyolysis (the breakdown of muscle into the blood stream) , Diabetes Mellitus Type II, End Stage Renal Disease, renal dialysis, history of trans-ischemic attack/cerebrovascular accident without residual, and C-Diff (clostridium difficile infection).<br><br>The admission MDS, dated 9/10/14, documented the resident received dialysis.<br><br>Admission physician orders, dated 9/3/14, documented:<br>*Glimepiride 2 mg (milligrams) po (by mouth) daily, Dx (diagnosis) Diabetes Mellitus, Type II<br>*Pioglitazone 15 mg (one) po daily, Dx: Diabetes Mellitus, Type II<br>*Oxygen: 2-4 lpm (liters per minute) sats(uration) (greater than) 90% PRN (as needed),<br>An additional physician order, dated 9/4/14, documented:<br>*Blood sugar checks (every) AM.<br><br>The resident's care plan for Diabetes Mellitus, dated 9/4/14, documented: *Observe for s/s (signs and symptoms) of hypoglycemia which | F 309 | Residents that reside in the center that are on insulin or an oral anti-diabetic medication, or have a diagnosis of diabetes mellitus have had their medical records reviewed and appropriate orders received by their treating physician for diabetes care.<br><br>Residents that reside in the center that are on insulin or an oral anti-diabetic medication, or have a diagnosis of diabetes mellitus have their meal intakes monitored and alternative meal and or a snack offered if an inadequate amount is consumed. If the alternative meal and/or snack are refused, the resident's blood glucose level will be checked by the nurse and physician notification will occur if needed per policy.<br><br>Residents that reside in the center that are on insulin, or oral anti-diabetic medication, and/or have a diagnosis of diabetes mellitus and attend dialysis, will have their meals provided before they leave if they will be gone during the meal time. | |

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| F 309 | Continued From page 3<br>included a change in level of consciousness,<br>*Observe for hyperglycemia with s/s which included change in level of consciousness, lethargy, confusion and weakness.<br>*Medication as ordered,<br>*Lab as ordered and report abnormal values promptly, and,<br>*Diet as ordered.<br><br>An Activities of Daily Living (ADL) flow sheet for the month of September 2014, documented that on day shift from 9/4 through 9/8, the resident required extensive assistance of 2 persons for transfers. On 9/9, however, the resident needed to be transferred by a Hoyer lift with 2 person assist. On 9/10 and 9/11 the resident was an extensive assist with one person.<br><br>The September 2014 Treatment Administration Record (TAR) documented the resident did not eat breakfast or dinner on 9/8 or breakfast on 9/9. There was no documentation that the resident received an evening snack on 9/8/14 or an early breakfast on 9/9/14.<br><br>NOTE: The resident had one meal documented as consumed in 24 hours, which was lunch on 9/8/14.<br><br>The September 2014 Medication Administration Record (MAR) documented that by 8:00 AM on 9/9/14, Resident #2 had received all of his morning medications, including Pioglitazone and Glimepiride. The MAR included space for BG documention, however the BG for 9/9/14 at 7:30 AM was illegible as an undecipherable number had been handwritten over the original entry.<br><br>The facility routinely ulitized a Dialysis Transfer | F 309 | Residents that reside in the center that attend dialysis have their fistulas checked per physician orders and receive the medical attention required after dialysis per policy.<br><br>• *Address what measures will be put in place to ensure deficient practice will not recur.*<br>Staff will be educated by the Director of Nursing and or designee on or before 10/28/14 on the new blood glucose monitoring protocol by the Director of Nursing and or designee.<br><br>Nursing staff will be re-educated by the Director of Nursing and or designee on or before 10/28/14 on the dialysis protocol and transfer forms are completed and sent to dialysis. | |

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| F 309 | Continued From page 4<br>Communication form to provide the dialysis center with the resident's medication changes, current lab values and any changes in medical or mental status. The dialysis center returned the form to the facility when the resident returned to the facility with a report of labs completed at the center, medications provided, follow-up care and recommendations.<br><br>The resident's Dialysis Transfer Communication form file did not document that he attended his dialysis appointment on 9/9/14, where he arrived at the dialysis center unresponsive and required emergent treatment by EMS for a BG of 30 taken immediately upon EMS arrival at the dialysis center.<br><br>A detached single page License Nurse Progress Note (LNPN) entry outside the flow of the 9/8/14 - 9/10/14 LNPN documentation, but dated 9/9/14, was provided to surveyors on 9/24/14. That LNPN documented:<br>*"0730 [7:30 AM] [LN #3] went to pt [patient] room to give meds and to get pt. ready for dialysis....pt assessment done pt somnotent [sic - somnolent] eyes reactive no signs of stroke v/s [vital signs] were normal....I was concerned about his condition and that I did not want to give him his medication for fear of aspiration. I went and read through the chart and looked at H & P [History and Physical] and labs I could not find any reason for pt to be like this she (wife) didn't want a glucose due to the bus is here to get him the bus took him to Dialysis."<br><br>LN #3 stated the v/s were normal; however, the record did not document v/s were taken on 9/9/14. The LN documented concern about the resident's condition but did not provide any detail | F 309 | Staff will be re-educated by the Director of Nursing and or designee on or before 10/28/14 on the meal management protocol. Education will include validating that residents that are diabetic receive their meals, and or follow-up from the nurse to avoid hyper and hypo glycemic episodes.<br><br>Staff will be re-educated by the Director of Nursing and or designee on or before 10/28/14 to advocate for residents if a change in condition is identified.<br><br>Nursing staff will be educated by the Director of Nursing and or designee on or before 10/28/14 on maintaining accurate and completed and organized clinical records. | |

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| F 309 | Continued From page 5<br>regarding that "condition."<br><br>A dialysis center incident report, dated 9/9/14 and completed by the LN who cared for the resident at the dialysis center, documented: "Non responsive on arrival for Tx (treatment). Wife stated pt was 'not normal' at facility before being transported to (name of dialysis center.)..." "Pt arrived for Tx (treatment) in W/C (wheelchair) slumped over & nonresponsive (with) blank stare. Informed wife we needed to send pt to ER & called 911.... O2 (oxygen) from care center was empty."<br><br>An Ambulance Service Patient Care Report documented the call from the dialysis center was received and emergency responders dispatched at 8:43 AM. The ambulance arrived at the dialysis center at 8:48 AM, and documented:<br>*08:50 AM: The primary impression was "Hypoglycemia." The assessment documented the resident's skin was cool and diaphoretic; LOC was unresponsive; there was no right or left arm movement; no right or left leg movement; stroke scale was not applicable; blood pressure 107/55; pulse 86; oxygen saturation 92%; BG 30; and the resident's Glasgow Coma Scale (GCS) was 6 out of 15 points.<br><br>The EMS narrative report documented: Report taken from the wife on scene was the resident had "been unresponsive since wife first saw him this morning" in the facility; "pt was placed in a whelchair by staff at (name of care center) and sent via facility van to his dialysis appointment." EMS treatment included: an IV (Intravenous catheter) was placed and the resident was administered 500 ml (milliliters) of D5 (Dextrose water). The "pt condition improved until pt returns | F 309 | • ***How will the plan be monitored to ensure the solutions are sustained?***<br>Audits for the identified issues will begin on 9/27/14 to be completed 5 days a week X4 weeks, 3 days a week X4 weeks, and 1 day a week X8 weeks by the Director of Nursing or designee to validate that diabetic and dialysis patients are receiving their meals.<br><br>Audits for the identified issues will be begin on 9/27/14 to be completed 5 days a week X4 weeks, 3 days a week X4 weeks, and 1 day a week X8 weeks by the Director of Nursing or designee to validate that blood glucose orders are being followed.<br><br>Audits for the identified issues will begin on 9/27/14 to be completed 5 days a week X4 weeks, 3 days a week X4 weeks, and 1 day a week X8 weeks by the Director of Nursing or designee to validate dialysis communication forms are being completed. | |

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| F 309 | Continued From page 6<br>to baseline of AOx4 (alert and oriented x 4)."... BG went up to 150. The resident's GCS was 15.<br><br>A Dialysis Progress Note, dated 9/9/14 at 2:22 PM, and completed by the Dialysis centers Supervisor, documented, "Contacted nursing home about if they checked his blood glucose this am. I talked with [LN# 3] and he stated he assessed him and his lungs were clear and O2% ok but they did not have him listed as a diabetic. I asked him if he gets any diabetic meds. I requested a current med list. He was listed as DMII (Diabetes Mellitus Type II) as a secondary dx (diagnosis) on his med sheet. ( Physician) notified. (Physician) dc (discontinued) one of his diabetic meds."<br><br>The detached single page LNPN, dated 9/9/14, documented<br>3:00 PM: "Pt returned and looked much better. He had some glucose from ( EMS). The (dialysis center) called and said his blood glucose was 39 and asked if I had (checked) it....Talked with ( resident's MD) as far as can determine the pt never has been Hypoglycemic..."<br><br>On 9/25/14 at 9:30 AM, the Supervisor at the dialysis center was asked about the resident's condition on 9/9/14. The Supervisor stated the patient had come into the center slumped over and unresponsive; the staff thought he had a stroke and called 911. The resident's wife was present and stated that staff at the facility told her the staff at the dialysis center would "take care of it." The patient's oxygen tank was empty. The Supervisor stated she called LN# 3 and he told her the patient was assessed, but did not have a BG on 9/9/14. | F 309 | Findings will be brought to CQI Committee monthly for a minimum of three months and longer, until the issue has been resolved or until the committee deems no longer required.<br><br>*The ED is responsible for compliance*<br><br>*Compliance date is ~~10/28/14~~.* 11/3/14<br><br>Chg per facility request e-mail 11/4/14 DR | |

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| TETON POST ACUTE CARE & REHABILITATION | 3111 CHANNING WAY IDAHO FALLS, ID 83404 |

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| F 309 | Continued From page 7<br>On 9/25/14 at 10:15 AM, the EMS Division Chief stated the patient was totally unconscious and unresponsive when EMS personnel arrived at the dialysis center.<br><br>On 9/25/14 at 12:30 PM, the resident's wife stated she came in at 7:00 AM and her husband was not ready to go to dialysis. "He was out of it. I was scared to death; he was there but not responding." When asked what the LN did when she expressed her concern, the wife stated, "I said I don't know what to do, he is not right, but he is supposed to go over and have dialysis. I was panicked... I had no idea what could have been wrong." When asked whether the resident had spoken to her during the facility van ride to the dialysis center on 9/9/14, the resident's wife stated, "He would acknowledge that I was there, but did not talk." The resident's wife stated she did not think the facility van driver realized the situation. When asked whether facility staff had to transfer the resident with a Hoyer lift that morning, she stated, "Yes, that morning they did use the Hoyer lift." Prior to that morning, the resident was transferred with 2 staff. When asked if he remembered the incident, the resident stated, "No."<br><br>On 9/25/14 at 3:20 PM, the van driver stated she was CPR (cardiopulmonary resuscitation) certified, had been an RN (Registered Nurse) in Mexico years before, a Medical Technician, a CNA (Certified Nurse Aide), and was instructed in safety and seat belt training for the van. When asked what she would do if a resident became unconscious, she stated she would return to the facility or go to the ER. She was asked what she remembered about the resident on the morning of 9/9/14. The van driver stated she had retrieved | F 309 | | |

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| F 309 | Continued From page 8<br>the resident's dialysis book and entered the resident's room to find him "not his normal self," and his wife was in a hurry. The van driver said, "He moved but he didn't talk to me. He tried to open his eyes and nodded...The wife was putting on his coat and he was not helping to put it on. He didn't look good to me." The van driver stated she told LN# 3 to come in to see the resident and when he came into the room he stated he was concerned about the resident. The van driver stated the resident's wife instructed LN# 3 not to give her husband the medications and then she drove the resident to the dialysis center; she stated during the drive to the dialysis center the resident was "lethargic, eyes were closed and hands were hanging down." The van driver was asked the resident's condition when she brought him back to the facility and she stated, he was "like his old self, perky and talking."<br><br>NOTE: The communication form from the facility to the dialysis center for 9/9/14 could not be located by surveyors or produced by the facility during the complaint investigation survey.<br><br>On 9/25/14 at 4:35 PM the CNA who cared for the resident on 9/9/14, day shift, stated the resident was not himself, and she did not think he would have been able to eat his breakfast if it was offered. The CNA stated normally the resident would have been up and ready to go to his dialysis appointment and that morning, she was "concerned" about the resident. The CNA said she told LN #3 about her concerns and he checked the resident.<br><br>The facility's Blood Glucose Monitoring policy, updated July 2014, directed staff to notify the physician for BG levels either below 70 mg/dl or | F 309 | | |

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| F 309 | Continued From page 9<br>above 400 mg/dl when signs and symptoms of hypo- or hyperglycemia were present, and provided direction for how to manage insulin when a resident's BG was outside of the set parameters of 70-400. The policy did not provide guidance on oral diabetic medication management, either for normal or abnormal BG measurements.<br><br>On 9/25/14 at 5:35 PM, the resident's physician, who was also the Medical Director of the facility, was asked whether he endorsed the facility's diabetic policy, which did not address oral diabetic medications.<br><br>The physician stated that he agreed with the policy and noted, "You aren't going to see hypoglycemia in resident's with oral medications," for Type II diabetes.<br><br>NOTE: According to the American Diabetes Association, (http://www.diabetes.org/living-with-diabetes/know-your-rights/discrimination/employment-discrimination/safety-issues.html) " ... severely low blood glucose (hypoglycemia), occur only in people receiving certain treatments such as insulin or certain oral medications ..."<br><br>When asked what he would expect if a resident exhibited s/s of hypoglycemia (low blood sugar), he stated he would expect the LN to call him and get a BG. When asked what he would expect if the BG was high, he stated they (facility nursing staff) graduated from nursing school, he trusted the nursing staff's judgment and he would expect them to get a BG. The physician was asked if he was notified when the resident had the significantly low BG of 30 (the reading obtained | F 309 | | |

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| F 309 | Continued From page 10<br>by EMS). He stated he could not specifically remember the incident, or whether he was told about it. The physician stated he was not in the facility at that time and, therefore, he would not have documented it. He stated he would expect nursing to document they had notified him.<br><br>On 9/25/14 at 6:10 PM, the DON stated LN# 3 caring for Resident #2 told her the resident did not want to eat breakfast, he was lethargic, had a dialysis appointment and that staff were concerned about him. When the DON was asked whether the facility investigated what happened when the resident was transported and delivered by the facility to the dialysis center unresponsive and with a BG of 30, or whether LN #3 was aware of s/s of hypoglycemia, she stated, "No." The DON agreed that on 9/9/14 the LNPN did not document any concerns about the resident that LN #3 may have had. The DON could not determine when the illegible BG had been taken or documented, nor what the actual recorded reading had been.<br><br>(NOTE: LN #3 caring for Resident #2 that day stated he did not measure the resident's BG prior to the 9/9/14 transfer to the dialysis center.).<br><br>Furthermore, the resident had eaten 1 meal in 24 hours and was documented to have received his morning medications, despite exhibiting s/s of hypoglycemia. The facility's policy did not address the monitoring of blood glucose levels or oral diabetic medication management. The facility had not generated a dialysis communication form for 9/9/14, and there was no documentation the physician or dialysis center had been notified of the resident's change of condition on the morning it occurred. | F 309 | | |

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| F 309 | Continued From page 11<br><br>The Administrator was asked when he became aware of the incident on 9/9/14 and he stated "probably" the next day (9/10/14) in the facility's stand up meeting. The Administrator was asked if an I&A form (Incident and Accident) should have been completed for 9/9 and he stated it didn't follow the parameters of a "typical" I&A. When was asked if he thought a medical event that required emergent care by the EMS should have prompted an investigation, the Administrator did not answer.<br><br>On 9/26/14 at 12:00 noon, the resident's physician was asked if he considered a BG of 30 as a critical value, to which he stated, "Yes, absolutely, yes that's low and definitely needs to be evaluated. That definitely should be caught (as a concern)." When asked if he would have expected an investigation to be completed on 9/9 concerning the event, the physician stated, "Certainly, that just makes sense." The physician was asked if a BG of 30 could cause death, and he stated, "Certainly, that can be concerning for possible death."<br><br>2. Resident # 3 was readmitted to the facility on 9/10/14 with diagnoses that included DMII (Diabetes Mellitus Type II), Endstage Renal Disease and Renal Dialysis.<br><br>The resident's physician admission orders, dated 9/10/14, documented:<br>*Autolet BS (blood sugar) (before) meals & bedtime.<br>*Insulin Lispro (Humalog) subcut(aneous) per sliding scale: 0-200: 0 units,<br>201-250: 2 units, 251-300: 3 units, 301-400: 4 units, 401+: 5 units. | F 309 | | |

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| F 309 | Continued From page 12<br><br>Resident #3's Dialysis Care Plan documented the resident was scheduled to receive dialysis every Monday, Wednesday, and Friday at 12:15 p.m.<br><br>The resident's MAR for September 2014 did not contain consistent documentation as per physician orders as follows:<br><br>Humalog 100 unit/ ml (milliliter) per sliding scale: Blood Glucose and dose of insulin administered was blank at 7:30 AM on 9/23/14; 11:30 AM on 9/18, 9/21, and 9/23; and at 5:00 PM on 9/11, 9/18, 9/20, 9/21 and 9/23/14.<br><br>On 9/25/14 at 5:20 PM, the DON was asked to explain the blank spaces on the resident's MAR for glucose monitoring in the diabetic resident and she stated the OOF means the resident was out of the facility and the missing documentation is where the nurse did not document it. The DON was asked if the resident's blood glucose had been measured.and she stated, "I can't say that it wasn't done, it wasn't documented."<br><br>On 9/26/14 at 12:40 PM, the Administrator and DON were notified of the findings. No additional information was provided.<br><br>3. Resident #1 was admitted to the facility on 8/12/14 at 1:30 PM with multiple diagnoses which included End Stage Renal Disease as the primary diagnosis and diabetes mellitus as the secondary diagnosis.<br><br>Resident #1's Admission Physician Order Sheet, dated 8/12/14, documented an order for "Insulin Lantus 15 U [units] Sub Q [subcutaneous] @ [at] | F 309 | | |

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| F 309 | Continued From page 13<br>bedtime." The September 2014 Physician Order Sheet documented an order for "Humalog 100 units/ml (Carb Dosing) subcutaneous. After Meals: Give 1 unit per 10 G (grams) carbs, check BG (blood glucose) TID [three times daily] at 8:30 AM, 1:30 PM and<br>6:30 PM" with a start date of 8/12/14.<br><br>A fax dated 8/18/14 documented, "RD recommends D/C [discontinue]<br>of carb count (admit order: carb dosing TCU [Transitional Care Unit]) Resident BG, WNL [within normal limits]. Resident on vegetarian diet and doesn't follow vegetarian diet orders from RD. Res[ident] makes dietary choices as food arrives in room." The physician wrote, "Agree" on the faxed order sheet and signed it on 8/21/14. A nurse documented as performed on 8/22/14 at 2:10 AM.<br><br>The following Progress Notes documented:<br>*"8/23/14 at 1:45 AM, "D/C carb count;"<br>*8/23/14 at 4:45 PM, "Blood glucose 129, carb count insulin orders were discontinued but BG's are WNL;" and,<br>*8/24/14 (not timed), "Cont[inue] to monitor Resident B/G."<br><br>On 8/26/14 a physician order documented the following:<br>*"1) D/C carb count;<br>*2) D/C sliding scale insulin; and,<br>*3) D/C Lantus."<br><br>An order to discontinue Blood Glucose levels TID was not written by the physician.<br><br>Review of the resident's MAR for August 2014, documented the resident did not have blood | F 309 | | |

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| F 309 | Continued From page 14<br>glucose levels for the following dates and times:<br>*8:30 AM, 8/23/14 through 9/24/14;<br>*1:30 PM, 8/14,15,17, and 19 through 9/24/14; and<br>*6:30 PM, 8/17, 19 through 9/24/14.<br><br>On 9/26/14 at 10:50 AM, the DON was interviewed in the presence of the Administrator, both of whom were made aware of the inconsistent charting of blood glucose levels. When asked if the facility had an order to discontinue checking BG levels TID, the DON stated, "Since the carb count was DC'd on 8/22/14, it was assumed the BG levels no longer needed to be taken."<br><br>NOTE: The actual order to "DC the carb count," was dated 8/26/14.<br><br>When told the facility needed an order to discontinue checking BG's TID before discontinuing the order, the DON stated, "Okay, I understand that." When asked if there was any documentation BG levels were discontinued, the DON stated, "Nope."<br><br>The facility's staff failed to follow the diabetic management policy to notify the physician of critically low levels or when residents were exhibiting signs and syptoms of hypoglycemia. The facility's policy and procedure was silent as to care and services for residents with diabetes managed by oral agents. In addition, the facility failed to ensure physician orders for diabetic care and treatment were implemented when the resident was out of the facility or to monitor for signs of hypoglycemia upon their return. The cumulative effect of these systematic failures placed individuals with diabetes at risk of | F 309 | | |

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| F 309 | Continued From page 15<br>experiencing serious and immediate harm and/or death resulting from severe hypo- or hyperglycemic events. | F 309 | | |
| F 490<br>SS=D | 483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING<br><br>A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, and facility staff and EMS Chief Director interview, it was determined the facility failed to ensure the Administrator identified a critical event had occurred in 1 (#2) of 4 sampled residents and could occur in any resident admitted with diabetes on oral diabetic medication. The deficient practice had the potential to cause harm when Resident #2 experienced a critical hypoglycemic event. The Administrator was notified of the event and did not initiate an investigation or changes to ensure the same type of event did not occur again.<br>Findings included:<br><br>1. Resident # 2 was admitted to the facility on 9/3/14 with diagnoses that included muscle weakness, Rhabdomyolysis, Diabetes Mellitus Type II, End stage Renal Disease, Renal Dialysis, history of trans-ischemic attack/stroke without residual and C-Diff (clostridium difficile infection.)<br><br>The resident had an observed change in level of consciousness the morning of 9/9/14 while in the | F 490 | *F490*<br>• ***How corrective action accomplished for the identified residents?***<br>LN#3 no longer works at the facility as of 9-28-14.<br><br>On 9/26/14, resident #2's blood glucose levels were reviewed by the Director of Nursing and or designee, and an HgbA1C lab drawn on 9/28/14, which is to be repeated every three months.<br><br>On 9/26/14 resident #3 blood glucose records were reviewed and updated to reflect the new Diabetic Monitoring policy by the Director of Nursing and or designee, and an HgA1C lab was drawn on 9/28/14 which is to be repeated every three months.<br><br>On 9/26/14 resident #1's medical record was reviewed by the Director of Nursing and or designee, and an order was received to discontinue TID blood glucose checks. A new order was received to check blood glucose one time weekly in the AM. And a HgbAlC lab was drawn on 10-3-14 to be repeated every three months.<br><br>An Event investigation was completed on before 10/23/14.<br><br>• ***How you will identify other residents with the potential of being affected by the same practice?*** | |

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| F 490 | Continued From page 16<br>facility and was sent to dialysis without documented assessment and interventions. Upon arrival at the dialysis center, the resident had a documented BG (blood glucose) of 30 and received emergent treatment to reverse the critical value. Refer to F309 for details of the event.<br><br>On 9/25/14 at 7:00 PM, the Administrator, with the DON present was asked when he was notified of the the incident on 9/9/14. He stated the next day in the facility's morning meeting. The Administrator was asked if he had completed and Incident and Accident report or followup investigation; he stated, "No."<br><br>On 9/26/14 at 12:40 PM, the Administrator and the DON were notified of the findings. No additional information was provided by the facility.<br><br>On 10/1/14 at 10:15 AM, the EMS Division Chief was asked to clarify when he had spoken with the Adminstrator about the event. He stated, "I went over there to talk to the Adminstrator that day (9/9/14). The report wasn't even complete but I wanted to let them know what happened." | F 490 | The facility has stopped admitting diabetic residents until the facility is placed in compliance.<br><br>The facility has updated its policy on blood glucose monitoring protocol on 9/26/14. The revised policy includes; blood glucose physician notification parameters, and guidance for those residents that take oral anti-diabetic medication.<br><br>Residents that reside in the center that are on insulin or an oral anti-diabetic medication, or a diagnosis of diabetes mellitus have had their medical records reviewed and appropriate orders received by their treating physician for diabetes care.<br><br>Residents that reside in the center that are on insulin or an oral anti-diabetic medication, or a diagnosis of diabetes mellitus have their meal intakes monitored and alternative meal and or a snack offered if an inadequate amount is consumed. If the snack is refused the resident's blood glucose level will be checked by the nurse<br><br>Residents that reside in the center that are on insulin or an oral anti-diabetic medication, and/or have a diagnosis of diabetes mellitus have that attend dialysis will have their meals provided before they leave if they will be gone over the meal time. | |
| F 501<br>SS=D | 483.75(i) RESPONSIBILITIES OF MEDICAL DIRECTOR<br><br>The facility must designate a physician to serve as medical director.<br><br>The medical director is responsible for implementation of resident care policies; and the coordination of medical care in the facility.<br><br>This REQUIREMENT is not met as evidenced | F 501 | | |

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| F 501 | Continued From page 17<br>by:<br>Based on record review, interview with facility staff and the Medical Director and review of the facility's diabetic policy, it was determined the facility failed to ensure the Medical Director developed and implement policies to manage residents in the facility with oral diabetic medications. This was true for 1 of 4 sampled residents (#2) and had the potential to affect any resident in the facility with diabetes who was on oral medications. Failure to ensure the facility's policies addressed complications that may occur with the use oral diabetic medications and how to treat residents when Blood Glucose (BG) levels were outside the facility's parameters for physician notification placed residents at risk for harm. Findings included:<br><br>The facility's policy for Blood Glucose Monitoring Protocol documented numerous "signs" of low and high BG levels, to notify the physician if the BG level was below 70 or above 400 based on finger-stick readings, and how to manage insulin if the BG was out of the parameters that were set. The policy did not address how to manage residents who were on oral diabetic medications or what to do if their BG levels were outside the parameters set.<br><br>1. Resident # 2 was admitted to the facility on 9/3/14 with diagnoses that included muscle weakness, Rhabdomyolysis (tumor of striated muscle), Diabetes Mellitus Type II, End Stage Renal disease, renal dialysis, history of trans-ischemic attack without residual (stroke) and C-Diff (clostridium difficile infection).<br><br>The resident's admission physician orders, dated 9/3/14, included: | F 501 | Residents that reside in the center that attend dialysis have their fistulas checked per physician orders and receive the medical attention required after dialysis per policy.<br><br>The Alert Charting report is reviewed in daily (Monday – Friday) clinical meeting. If an event is identified, appropriate event investigation and QAA process, including root cause analysis, will be initiated.<br><br>• ***Address what measures will be put in place to ensure deficient practice will not recur.***<br>The Administrator and the Director of Nursing were provided education on or before 10/05/14 by the Regional Vice President about when an Incident and Accident reports or follow-up investigation needs to be completed.<br><br>Nursing staff were educated by the Director of Nursing and or Designee on or before 10/28/14 about when an Incident and Accident report or follow-up investigation needs to be completed.<br><br>The Interdisciplinary Team and Administrator will receive re-education by the Regional Vice President on or before 10/21/14 on when an Incident and Accident report or follow-up investigation is required to include all substantial events. | |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| TETON POST ACUTE CARE & REHABILITATION | 3111 CHANNING WAY IDAHO FALLS, ID 83404 |

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| F 501 | Continued From page 18<br>*Glimepiride 2 mg (milligrams) po (orally) and Pioglitazone 15 mg (one) po daily - both anti-diabetic medication; and,<br>*Oxygen: 2-4 lpm (liters per minute) sats(uration) (greater than) 90% PRN (as needed).<br>A physician order dated 9/4/14, documented:<br>*Blood sugar checks (every) AM.<br><br>The resident had an observed change in level of consciousness the morning of 9/9/14 while in the facility and was sent to dialysis without interventions. Upon arrival at the dialysis center, dialysis center staff notified Emergency Medical Services (EMS) of the resident's condition. EMS reported that the resident's BG level was 30 when they arrived at the dialysis center to treat the resident. Refer to F309 for details of the incident.<br><br>The resident's single page LNPN dated 9/9/14 at 3:00 PM, documented, "Pt returned and look much better. He had some glucose from (name of EMS). The (name of dialysis center) called and said his blood glucose was 39 and asked if I had (checked) it....Talked with (name of resident's MD) as far as can determine the pt never has been Hypoglycemic..."<br>NOTE: The resident's physician, who was also the Medical Director of the facility, was notified on 9/9/14 at 3:00 PM, that the resident had a BG of 39 at dialysis and had been treated for hypoglycemia. The physician made no changes in the resident's care or the facility's BG monitoring policy.<br><br>On 9/25/14 at 5:35 PM, the surveyor interviewed the Medical Director of the facility. The Administrator and the DON were present. The physician was asked if he agreed with the facility's diabetic policy that did not address oral | F 501 | • *How will the plan be monitored to ensure the solutions are sustained?*<br><br>Audits for the identified issues will begin on 10/23/14 to be completed 3 days a week X4 weeks, 2 days a week X4 weeks, and 1 day a week X8 weeks by the Director of Nursing and or designee to validate that 24 hour report is reviewed and events identified have an investigation completed.<br><br>Audits for the identified issues will begin on 10/23/14 to be completed 3 days a week X4 weeks, 2 days a week X4 weeks, and 1 day a week X8 weeks by the Regional Vice President and or designee to validate Accident and Incident reports and or follow-up investigations are being completed for the appropriate events.<br><br>Findings will be brought to CQI Committee monthly for a minimum of three months and longer until the issue has been resolved or until the committee deems no longer required.<br><br>*The ED is responsible for compliance*<br><br>*Compliance date is ~~10/28/14~~.* 11/3/14<br><br>Chg per facility request 11/4/14 | |

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| F 501 | Continued From page 19<br>diabetic medications. The physician stated he did agree with the policy and, "You aren't going to see hypoglycemia [low BG levels] in resident's with oral medications," for Type II Diabetes. The physician was asked if he was notified when the resident had the significantly low BG of 30. He stated he could not specifically remember the incident, but if he was told about it and was not in the facility, he would not document it. He stated he would expect nursing to document they had notified him.<br><br>On 9/26/14 at 12:00 noon, the Medical Director was asked if a BG of 30 could cause death, and he stated, "Certainly that can be concerning for possible death...I would agree with you .. needs an obvious clarification...even po medication. I'm glad you are looking at this as we need to look at our policies for diabetics."<br><br>On 9/26/14 at 12:40 PM, the Administrator and the DON were notified of the findings. No additional information was provided. | F 501 | *F501*<br>• ***How corrective action accomplished for the identified residents?***<br>On 9/26/14 resident #2 had his blood glucose levels reviewed by the Director of Nursing and or designee, and a HgbA1C lab was drawn on 9/28/14, which is to be repeated every three months.<br><br>• ***How you will identify other residents with the potential of being affected by the same practice?***<br>The facility has stopped admitting diabetic residents until the facility is placed in compliance.<br><br>The facility has updated its policy on blood glucose monitoring protocol on 9/26/14. The revised policy includes: blood glucose physician notification parameters, and guidance for those residents that take oral anti-diabetic medication.<br><br>Residents that reside in the center that are on insulin or an oral anti-diabetic medication, and/or have a diagnosis of diabetes mellitus have had their medical records reviewed and appropriate orders received by their treating physician for diabetes care. | |
| F 514<br>SS=D | 483.75(l)(1) RES<br>RECORDS-COMPLETE/ACCURATE/ACCESSIBLE<br><br>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.<br><br>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; | F 514 | | |

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| F 514 | Continued From page 20<br>and progress notes.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interview, it was determined the facility failed to maintain accurate, complete and organized clinical records for each resident. This was true for 3 of 4 sampled residents (#'s 1, 2, and 3) reviewed for clinical records. This deficient practice increased the risk for medical decisions to be based on incomplete or inaccurate information and increased the risk for complications due to inappropriate care and/or interventions. Findings included:<br><br>1. Resident #1 was admitted to the facility on 8/12/14 with multiple diagnoses including end stage renal disease and diabetes mellitus.<br><br>August and September 2014 Treatment and Medication Records did not contain consistent documentation as ordered on the Admission Orders and September 2014 Physician Order Sheets (recapitulation) for the following:<br>*Special Meal Provisions: Sack Lunch, Early Meal - No documentation on 8/30 and 9/6;<br>*Coordinate Medication regime with dialysis center - No documentation on 8/30 and 9/6;<br>*Information Sheet returned from Dialysis - No documentation on 8/30, 9/2 and 9/6;<br>*When resident returns from Dialysis, assess blood flow for fistula or grafts on either side of dressing - No documentation on 8/30, 9/2, 6, 9, 11, 16 and 18;<br>*Fluid restriction of 1000 cc's per day - No documentation for day shift on 8/16, 17, 18, 24, 30, and 9/14 or night shift on 8/26, 27, 29, 9/9, | F 514 | • ***Address what measures will be put in place to ensure deficient practice will not recur.***<br>The facility's medical director was educated to the new Diabetic Monitoring Policy and Protocol verbally on 9/26/14 by the Director of Nursing and Administrator. He was educated to the changes in the new Diabetic Monitoring Protocol in writing on 10/17/14.<br><br>Notification will be sent by the Health Information Manager and or designee to resident's primary care physicians in writing to provide education on new Diabetic Monitoring Protocol.<br><br>• ***How will the plan be monitored to ensure the solutions are sustained?***<br>Audits for the identified issues will begin on 10/23/14 to be completed 3 days a week X4, or until each resident's primary care physicians has return a signed copy of the new Diabetic Monitoring Protocol. | |

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| F 514 | Continued From page 21<br>and 11;<br>*Monitor dialysis catheter for signs and symtoms of infection, edema, ischemia, bleeding, dislodgement and presence if cathether cap in place every shift - No documentation for day Shift on 8/24, 29, 30, 9/14 and 23 or night shift on 8/26, 27, 29, 31 and 9/9;<br>*Palpate fistula or graft for thrill presence or absence every shift - No documentation for day shift on 8/24, 9/2, 3, 12, and 14 or night shift on 8/31, 9/9, and 23;<br>*Auscultate fistula or graft for bruit presence or absence every shift - No documentation for day shift on 8/24, 9/2, 3, 12, and 14 or night Shift on 9/9 and 23;<br>*Monitor extremity or area of fistula/graft for changes in circulation, movement, sensation - No documentation for day shift on 8/24, 9/3, 6, 9, 10, 11 and 14 or night Shift on 9/9 and 23;<br>*Coordinate Med regime with Dialysis Center send a copy of the current MAR with documentation of any changes in the resident condition and any new labs obtained - No documentation on 9/2 and 23;<br>*Check BG's (blood glucose levels) TID (three times daily) - Not documented TID from 8/19 through 9/24;<br>*HS Snack was accepted or refused - No documentation on 8/29, 9/9, and 23;<br>*Check 02 (oxygen) Sats (saturation levels) by shift for: LPM (Liters Per Minute) - No documentation on day shift on 9/3, 5, 7, 9, 13, 14, and 24 or night shift on 9/10 and 23; No documentation of 02 Sats on day shift on 9/14 and 19 or night shift on 9/10 and 23;<br>*Change 02 Tubing and date label every week- No documentation on 9/21;<br>*Pulse or systolic blood pressure for the medication Norvasc 10 mg - No documentation | F 514 | Audits for the identified issues will begin on 10/23/14 to be completed 3 days a week X4 weeks, 2 days a week X4 weeks, and 1 day a week X8 weeks by the Director of Nursing and or designee to validate that residents who have been prescribed insulin, an oral anti-diabetic medication, and/or that have a diagnosis of diabetes mellitus have had their medical records reviewed and appropriate orders received by their treating physician for diabetes care.<br><br>Findings will be brought to CQI Committee monthly for a minimum of three months and longer until the issue has been resolved or until the committee deems no longer required.<br><br>*ED is responsible for compliance*<br><br>*Compliance date is* 10/28/14.<br><br>*F514*<br>• *How corrective action accomplished for the identified residents?*<br>LN#3 no longer works at the facility as of 9/28/14<br><br>Resident #1's Medical Records, Treatment Record, and Meal Monitor have been reviewed for accuracy on or before 10/28/14. | |

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| F 514 | Continued From page 22<br>on 9/6;<br>*Nystatin Powder - No documentation for day shift on 9/6 and 14 or night shift on 9/9 and 9/18;<br>*Lipitor 40 mg - No documentation it was given on 9/19;<br>*Coreg 25 mg at 8:00 PM - No documentation it was given on 9/10, and 17;<br>*Clonidine HCL 0.1 mg - No documentation it was given at 8:00 AM on 9/4 and 11 or at 8:00 PM on 9/10 and 17;<br>*Hydralazine HCL 100 mg - No documentation it was given three times per day at 8:00 AM on 9/12 and 23, at 2:00 PM on 9/2, 9, 18 and 23, or at 8:00 PM on 9/10;<br>*Nitroglycerin Patch 0.6 mg/hr transdermal 24 hours - No documentation it was given on 9/9;<br>*Aspirin 81 mg - No documentation it was given on 9/9;<br>*Zinc Sulfate 220 mg - No documentation it was given on 8/24, 26, 29 and 9/15;<br>*Protonix 40 mg - No documentation it was given at 6:00 AM on 8/28 or at 5:00 PM on 8/29, 9/12, and 15; and,<br>*Multivitamin with minerals - No documentation it was given on 8/29, 31 and 9/12.<br><br>On 9/24/14 at 5:05 PM, the surveyor requested a copy of the Progress Notes for Resident #1. The last entry documented in the Progress Notes was dated 9/21/14 as a late entry. The Progress Note contained a total of five lines which were illegible. The second line contained a blood sugar which was illegible.<br><br>On 9/26/14 at 10:50 AM, the DON was interviewed in the presence of the Administrator. The DON was asked to review Resident #1's Treatment and Medication Records for the months of August and September of 2014. The | F 514 | Resident#2 discharged from the facility on 10/4/14.<br><br>Resident #3 Medical Records, Treatment Record, and Meal Monitor have been reviewed for accuracy on or before 10/28/14.<br><br>• ***How you will identify other residents with the potential of being affected by the same practice?***<br><br>The facility has stopped admitting diabetic residents until the facility is placed in compliance.<br><br>Medical Records, Treatment Records, and Meal Monitors have been reviewed for residents to validate accuracy and consistent documentation as identified on Admission Orders, Physician Order, by the Director of Nursing and or designee.<br><br>Resident's dialysis transfer forms have been reviewed by the Director of Nursing and or designee for accuracy and completion. | |

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| F 514 | Continued From page 23<br>DON shook her head up and down and stated, "There are holes in the documentation...the holes in documentation are probably more than one nurse but I feel the majority of it is due to one nurse."<br><br>The surveyor asked the DON for Resident #1's BG level after the 8/19/14 BG documented at 8:30 AM, however, the facility did not provide any documentation. When asked if there was an order to discontinue the BG levels, the DON stated, "Nope."<br><br>The surveyor asked the DON if she was able to read the 9/21/14 Progress Note. The DON shook her head no and stated, "That's [LN #3]'s note and we have talked with him about his penmanship because it has been a problem." When asked if she was able to read the blood sugar number, the DON stated, "It looks to me like 395." The DON then handed the Progress Note to the Administrator who stated, "It looks to me like 348." The DON was asked if there was any follow-up documentation for a BG this high, the DON stated, "I can't speak to this note," regarding a follow-up.<br><br>The surveyor examined the 9/21/14 Progress Note page, which was copied on the evening of 9/24/14, with the DON and Administrator and compared it to the 9/21/14 Progress Note in the medical record. The surveyor, DON and Administrator all acknowledged the medical record Progress Note had documentation for 9/22/14 and 9/23/14, which was not on the copy provided to the surveyor on 9/24/14. The Progress Note entries for 9/21, 22, and 23 were written by the same nurse. The Administrator stated, "It needs to be dated and timed, there is | F 514 | • *Address what measures will be put in place to ensure deficient practice will not recur.*<br><br>Nursing staff will be educated by the Director of Nursing and or designee on or before 10/28/14 on maintaining accurate, completed and organized clinical records.<br><br>Nursing staff will be re-educated by the Director of Nursing and or designee on or before 10/28/14 on completed the dialysis transfer form completely.<br><br>• *How will the plan be monitored to ensure the solutions are sustained?*<br>Audits for the identified issues will begin on 10/23/14 to be completed 3 days a week X4 weeks, 2 days a week X4 weeks, and 1 day a week X8 weeks by the Director of Nursing and or designee to validate that Medication Record, Treatment Record, and Meal Monitors are maintain accurately, complete, and organized. | |

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| F 514 | Continued From page 24<br>no late entry." The DON and Administrator both stated they had been working with this nurse, trying to help him.<br><br>2. Resident # 2 was admitted to the facility on 9/3/14 with diagnoses that included muscle weakness, Rhabdomyolysis (breakdown of muscle into the bloodstream), Diabetes Mellitus Type II, End Stage Renal Disease, renal dialysis, history of trans-ischemic attack/stroke without residual and C-Diff (clostridium difficile infection).<br><br>The facility utilized a Dialysis Transfer form to provide communication to the dialysis center on medication changes, new labs and any changes in medical or mental status since the resident's last visit to dialysis center. The dialysis center then returned the form when dialysis was completed with the resident to inform the facility of the resident's dialysis treatment with any recommendations, labs completed, medications provided at the center, and resident's weight.<br><br>The resident's Dialysis Transfer form documented visits for 9/4/14, 9/6/14, 9/11/14, and 9/13/14. A communication form was not initiated for 9/9/14, which was the day the resident had a change of condition in the facility. Refer to F 309 for additional information about the resident's condition.<br><br>The resident's record, per the physicians admit orders dated 9/10/14, contained two Medication Administration Records (MARs). One was hand generated (HMAR) and one was computer generated (CMAR). The resident's record contained two Treatment Administration Records (TARs), one was hand generated (HTAR) and one was computer generated (CTAR). The | F 514 | Audits for the identified issues will begin on 10/23/14 to be completed 3 days a week X4 weeks, 2 days a week X4 weeks, and 1 day a week X8 weeks by the Director of Nursing and or designee to validate that dialysis communication forms are complete and accurate.<br><br>Findings will be brought to CQI Committee monthly for a minimum of three months and longer until the issue has been resolved or until the committee deems no longer required.<br><br>*The ED is responsible for compliance*<br><br>*Compliance date is ~~10/28/14.~~* 11/3/14<br><br>Chg per facility request 11/4/14 DS | |

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| F 514 | Continued From page 25<br>records contained inconsistent documentation as follows:<br><br>*9/9/14: HMAR documented the resident received fourteen scheduled medications.<br>9/9/14: HMAR documented a BG which was illegible with an original mark and another mark over the top of it.<br>9/9/14: CMAR documented fourteen scheduled medications with three of the medications documented as administered. The blood pressure (b/p) medication adminstered required a b/p be taken; however, it was not documented. The space for a BG was blank. Side effects of antipsychotic medications were not documented.<br><br>*9/10/14: HMAR documented the resident received thirteen scheduled medications. One diabetic medication had been discontinued. The space for a BG was blank.<br>* 9/10/14: CMAR documented fifteen scheduled medications. An antibiotic had been ordered/added. Six scheduled medications were documented as administered. The space for a BG was blank.<br><br>*9/21/14: CMAR documented the resident received a b/p medication; however, a b/p was not documented.<br><br>*9/23/14: CMAR documented the resident received a b/p medication; however, a b/p was not documented.<br><br>The CTAR documented;<br>*"Ted hose on in AM and Of [sic - off] at [night]," were not signed for day shift on 9/11/14, 9/13/14, and 9/14/14. From 9/9/14 through 9/24/14, the boxes to check that the Ted Hose were "on" was | F 514 | | |

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| F 514 | Continued From page 26<br>blank. Night shift was was not signed on 9/17/14 and 9/18/14.<br>*Wound Care for a skin tear on the right forearm was blank for 9/10/14 and 9/17/14.<br>*Check oxygen saturations by shifts was blank for night shift on 9/18/14. Oxygen saturaton was not recorded for day shift on 9/14/14 and 9/15/14.<br>*Change oxygen tubing and date and label every week was blank on 9/14/14.<br>*Dialysis information - returned from dialysis center was blank on 9/13/14.<br>*Special meal provisions for sack lunch, early was blank on 9/9/14 and 9/16/14.<br>*Assessment for blood flow of Fistula or Graft was blank on 9/13/14.<br>*Monitor Dialysis catheter for signs and symptoms of infection was blank for day shift on 9/13, 9/14, 9/19, and 9/22/14. On night shift it was blank for 9/9, 9/10, 9/11, 9/17, 9/18, 9/20 and 9/21.<br>*Palpate Fistula or Graft for thrill was blank for day shift on 9/13, 9/14, 9/15, and 9/19/14. For night shift it was blank on 9/9, 9/10, 9/17, 9/18, 9/21 and 9/23/14.<br>*Auscultate Fistula or Graft for bruit for day shift was blank on 9/9, 9/10, 9/13, 9/14, 9/15, 9/19, 9/21, 9/22 and 9/23. For night shift it was blank on 9/9, 9/10, 9/17, 9/18, 9/21 and 9/23/14.<br>*Monitor extremity or area of Fistula/Graft for changes for day shift was blank on 9/9, 9/10, 9/11, 9/13, 9/14, 9/15, 9/21, 9/22, and 9/23/14. For night shift it was blank on 9/9, 9/10, 9/17, 9/18, 9/21 and 9/23/14.<br>*A Dialysis Flow Sheet dated Sept 2014 with hand written dates for the month, documented the same interventions as the CTAR for dialysis care. The flow sheet had signatures on 9/4, 9/13, and 9/24/14; the remainder of the days were blank. | F 514 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____ | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 135138 | | C 09/26/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TETON POST ACUTE CARE & REHABILITATION | 3111 CHANNING WAY<br>IDAHO FALLS, ID 83404 |

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| F 514 | Continued From page 27<br>The HTAR documented:<br>*Ted Hose on in AM off in PM was left blank for day shift on 9/19 and 9/20/14. Night shift was blank on 9/17 and 9/18/14.<br>*Left knee and right knee wound care every week was blank on 9/23/14.<br>*Left and right elbow wound care was blank on 9/19 and 9/23/14.<br>*Assessment for blood flow of Fistula or Graft was blank on 9/13/14.<br>*Check oxygen saturations by shifts was blank for night shift on 9/18/14 and a oxygen saturaton was not recorded for day shift on 9/14 and 9/15/14.<br>*Change oxygen tubing and date and label every week was blank on 9/14/14.<br><br>* The Monitor flow sheet for bladder continence was blank on day shift for 9/6, 9/21 and 9/22/14. For night shift it was blank on 9/18/14.<br>*The Monitor flow sheet for bowel continence was blank for day shift on 9/6, 9/16, 9/21 and 9/22/14. For evening shift it was blank on 9/18/14 and for night shift it was blank on 9/4/14.<br><br>On 9/25/14 at 6:10 PM, the DON, with the Administrator present, reviewed the two MARs and two TARs. When asked which MAR was supposed to be used and why there was random documentation on both sets, the DON stated the handwritten was the original MARS and within aproximately 48 hours, on new residents, a new computerized MAR was generated. When asked to explain why, if the resident had been admitted on 9/3/14 there was documentation on both MARs and TARs throughout the month, she stated, "I don't have an answer." The DON was unable to identify what the BG was for 9/9/14 on the HMAR. The DON agreed there was no documentation that the resident's fistula had been | F 514 | | |

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| F 514 | Continued From page 28<br>checked on 9/9/14.<br><br>3. Resident # 3 was readmitted to the facility on 9/10/14 with diagnoses that included Type II Diabetes Mellitus and End Stage Renal Disease and Renal Dialysis.<br><br>The September 2014 TARs and MARs did not include consistent documentation as identified on Admission Orders, Physician Order Sheets and Resident Activity of Daily Living flow sheets for the following:<br><br>*Humalog 100 unit/ ml (milliliter) per sliding scale: BG and dose of insulin adminsistered was blank at 11:30 AM on 9/18, 9/21, and 9/23/14 and at 5:00 PM on 9/11, 9/18, 9/20, 9/21 and 9/23/14;<br>*Vancomycin Hyrochloride 250 mg (milligram) every 8 hours was blank at 4:00 PM on 9/11/14, at 6:00 AM on 9/18, 9/20 and 9/21/14 and at 2:00 PM on 9/20 and 9/21/14.<br>*Albuterol/ Ipratropium inhaled nebulizer every 8 hours was blank at 4:00 PM on 9/11/14.<br>*Sucralfate 1 gr (gram) by mouth 4 times a day was blank at 4:00 PM on 9/10, 9/11, 9/19, 9/21 and 9/23/14. On day shift 9/23/14.<br>*Bacid 1 capsule by mouth three times a day was blank at 8:00 AM on 9/11 and 9/23/14. At 12:00 noon on 9/11, 9/12, 9/21 and 9/23/14.<br>*O2 (oxygen) at 2-4 LPM (liters per minute) to maintain saturations greater than 90 %. There was no documentation for saturation checks, on 9/10 or 9/11, and 9/18/14. On Day shift there was no documentation for 9/17/14.<br>*Weekly skin assessment was blank on 9/17/14.<br>*Monitor extremity or area of Fistula/Graft for changes was blank on Day and Night shift for 9/19 and 9/23, and on Day shift for 9/21, and 9/22/14. | F 514 | | |

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| F 514 | Continued From page 29<br>*Ausculate Fistula or Graft for bruit was blank on Night shift 9/23/14.<br>*When the residents returns from Dialysis, assess blood flow for Fistula or grafts on either side of dressing was blank on 9/17/14.<br>*Information sheet returned from Dialysis was blank on 9/17/14.<br>*Dialysis site care was blank on Day and Night shift on 9/18 and on Day shift on 9/24/14.<br>*Fluid Restriction of 1800 cc in 24 hours was blank on Night shift on 9/18 and did not document amount of intake on Night shift on 9/22 and 9/23. Day Shift was blank on 9/21, 9/22 and 9/23/14.<br>*Breakfast was blank on 9/21/14. Lunch was blank on 9/19/14.<br>*Monitor for Bowel continence was blank on Day shift for 9/16, 9/21 and 9/22/14. Evening shift was blank on 9/18 and 9/22/14.<br>*Monitor for Bladder continence was blank on Day shift on 9/16, 9/21 and 9/22. Evening shift was blank on 9/18 and 9/22/14.<br><br>On 9/25/14 at 5:20 PM, the DON was asked to explain the blank spaces on the resident's MAR for glucose monitoring and she stated the resident was out of the facility and the holes were where the nurse did not document the information. The DON was asked if the resident's blood glucose had been measured and she stated, "I can't say that it wasn't done, it wasn't documented."<br><br>On 9/26/14 at 12:40 PM, the Adminstrator and the DON were notified of the findings. No additional information was provided. | F 514 | *F520*<br>• ***How corrective action accomplished for the identified residents?***<br>Resident#2 discharged from the facility on 10/4/14.<br><br>On 10/15/14 the CQI committee discussed the root cause of resident #2's hypoglycemic event and how the new blood glucose monitoring protocol will prevent events likes from occurring again.<br><br>An Event investigation was completed on before 10/23/14.<br><br>• ***How you will identify other residents with the potential of being affected by the same practice?*** | |
| F 520<br>SS=D | 483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET | F 520 | | |

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| F 520 | Continued From page 30<br>QUARTERLY/PLANS<br><br>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.<br><br>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.<br><br>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.<br><br>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and interview with facility staff and Emergency Medical Services (EMS) staff, it was determined the facility failed to implement the facility's Quality Assessment and Assurance (QAA) process when 1 of 4 sampled residents (#2) experienced a critical hypoglycemic event at the facility, was transported in an unresponsive state to the dialysis center, and required emergent treatment by EMS. The facility's failure to implement the | F 520 | Residents that reside in the center that are on insulin or an oral anti-diabetic medication, and/or a diagnosis of diabetes mellitus have had their medical records reviewed and appropriate orders received by their treating physician for diabetes care.<br><br>The Alert Charting report is reviewed in daily (Monday – Friday) clinical meeting. If an event is identified, appropriate event investigation and QAA process, including root cause analysis, will be initiated.<br><br>• ***Address what measures will be put in place to ensure deficient practice will not recur.***<br>The Quality Assurance Committee will be re-educated by the Regional Vice President and or designee on or before 10/21/14 on developing a plan of action to validate we develop plans of action for substantial events. | |

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| F 520 | Continued From page 31<br>QAA process including initiation of a root cause analysis and development of a plan of action placed all residents in the facility with diabetes at risk for significant complications. Findings include:<br><br>Intent language for F520 states that the QAA committee is responsible for identifing quality deficiencies and developing and implementing plans of action to correct these quality deficiencies, including monitoring the effect of implemented changes and making needed revisions to the action plans.<br><br>The facility was cited at F309 for an Immediate Jeopardy when, on 9/9/14, it failed to identify and treat Resident #2 who experienced a critical hypoglycemic event that included a decline in LOC secondary to a critically low blood glucose level of 30. Refer to F309 for additional information.<br><br>The event was reported to the facility's administration; however, an investigation was not initiated. Refer to F490 for additional information.<br><br>The facility's Event Reporting and Investigation Policy, revised February 2007, documented definitions which included: 7. Substantial event: ii "Any event or happening, involving a resident, resulting in substantial, unintended, undesirable, and/or unexpected result or outcome." The policy described the process to document and what to report and to whom the event should be reported.<br><br>When asked about the facility's QAA process on 9/25/14 at 7:00 PM, the Administrator stated that a concern would be brought to the committee and the IDT (Interdisciplinary Team) would discuss the | F 520 | Nursing staff will be re-educated by the Director of Nursing and or designee on or before 10/28/14 on validating that events documented on the 24 hour report log is identified as appropriate have an event investigation completed.<br><br>• ***How will the plan be monitored to ensure the solutions are sustained?***<br>Audits for the identified issues will begin on10/23/14 to be completed monthly for X4 months by the Regional Vice President or designee to validate that QAA process occurs and substantial events are reviewed and plans of action are put in place. | |

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NAME OF PROVIDER OR SUPPLIER
TETON POST ACUTE CARE & REHABILITATION

STREET ADDRESS, CITY, STATE, ZIP CODE
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| F 520 | Continued From page 32 issue. The IDT would work through to the root cause, analyze the information and then address it. When asked if he was notified of the event that occurred on 9/9/14 to Resident #2, who was diabetic, he stated, "Probably the next day. It was discussed in our morning meeting." When asked if an incident report (I & A) been completed for this event, he stated it didn't follow the parameters of a typical I & A.<br><br>On 9/26/14 at 11:20 AM the DON was asked when she was notified of the incident that occurred on 9/9/14. The DON stated that on 9/9/14, between 9:00 and 9:30 AM, LN #3 notified the team, which consisted of the DON, Staff Development Coordinator, Charge Nurse, Rehabilitation staff, Social Services Manager and Administrator, of the event. The DON stated, "We talked about what needed to be documented, and if the physician had been notified."<br><br>During the course of the complaint investigation, the Division Chief for EMS was interviewed. On 10/1/14 at 10:15 AM, the Division Chief was asked, via telephone to clarify when he spoke to the facility's Administrator about the event. He stated, "I went over there to talk to the Administrator that day (9/9/14). The report wasn't even complete but I wanted to let them know what happened."<br><br>The facility did not investigate an event for which emergent medical treatment was required as the result of Resident #2 being transported from the facility without appropriate assessment and treatment for hypoglycemia. The facility failed to initiate the QAA process including root cause analysis and implemention of an action plan to prevent a reoccurrence of the incident. | F 520 | Audits for the identified issues will begin on 10/23/14 to be completed 3 days a week X4 weeks, 2 days a week X4 weeks, and 1 day a week X8 weeks by the Director of Nursing and or designee to validate that 24 hour report is reviewed and events identified have an investigation completed.<br><br>Findings will be brought to CQI Committee monthly for a minimum of three months and longer until the issue has been resolved or until the committee deems no longer required.<br><br>*The ED is responsible for compliance*<br><br>*Compliance date is ~~10/28/14.~~* 11/3/14<br><br>Chg per facility Request 11/4/14 | |

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Bureau of Facility Standards

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING | (X3) DATE SURVEY COMPLETED |
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| | MDS001775 | | C 09/26/2014 |

NAME OF PROVIDER OR SUPPLIER: TETON POST ACUTE CARE & REHABILITATIO

STREET ADDRESS, CITY, STATE, ZIP CODE: 3111 CHANNING WAY, IDAHO FALLS, ID 83404

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| C 000 | 16.03.02 INITIAL COMMENTS<br><br>The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2.<br>The following deficiencies were cited during the Complaint survey of your facility.<br><br>The surveyors conducting the survey were: Susan Gollobit, Team Coordinator, and Rebecca Thomas, RN, | C 000 | DISCLAIMER CLAUSE<br><br>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. | |
| C 105 | 02.100,02 ADMINISTRATOR<br><br>02. Administrator. The governing body, owner or partnership shall appoint a licensed nursing home administrator for each facility who shall be responsible and accountable for carrying out the policies determined by the governing body. In combined hospital and nursing home facilities, the administrator may serve both the hospital and nursing home provided he is currently licensed as a nursing home administrator.<br>This Rule is not met as evidenced by:<br>Refer to F 490 related to Administration. | C 105 | *C105*<br><br>Refer to the plan of correction on the 2567 for F490.<br><br>RECEIVED<br>OCT 2 3 2014<br>FACILITY STANDARDS<br><br>C731 | |
| C 731 | 02.154,01,c Consult/Assist Overall Managment of Services<br><br>c. Consult and assist in the overall management and delivery of patient care services.<br>This Rule is not met as evidenced by:<br>Refer to F 501 related to services of the Medical Director. | C 731 | Refer to the plan of correction on the 2567 for F501. | |

Bureau of Facility Standards
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 10-22-14

Bureau of Facility Standards

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING | (X3) DATE SURVEY COMPLETED |
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| C 784 | 02.200,03,b Resident Needs Identified<br><br>b. Patient/resident needs shall be recognized by nursing staff and nursing services shall be provided to assure that each patient/resident receives care necessary to meet his total needs. Care shall include, but is not limited to:<br>This Rule is not met as evidenced by:<br>Please refer to F-309 as it relates to highest practical care. | C 784 | *C784*<br>Refer to the plan of correction on the 2567 for F309. | |
| C 881 | 02.203,02 INDIVIDUAL MEDICAL RECORD<br><br>02. Individual Medical Record. An individual medical record shall be maintained for each admission with all entries kept current, dated and signed. All records shall be either typewritten or recorded legibly in ink, and shall contain the following:<br>This Rule is not met as evidenced by:<br>Please refer to F-514 as it relates to medical records. | C 881 | *C881*<br>Refer to the plan of correction on the 2567 for F514. | |

# IDAHO DEPARTMENT OF HEALTH & WELFARE

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

DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

November 19, 2014

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

FILE COPY

Provider #: 135138

Dear Mr. Spiers:

On **September 26, 2014**, a Complaint Investigation survey was conducted at Teton Post Acute Care & Rehabilitation. Susan Gollobit, R.N. and Becky Thomas, R.N. conducted the complaint investigation.

During the complaint investigation, the records of four residents including that of the identified resident were reviewed. In addition, the facility's policy regarding hypoglycemia/low blood glucose levels, dialysis center records and Emergency Medical Services (EMS) records were reviewed. Facility staff, dialysis center staff, EMS staff and resident's family members were interviewed.

The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00006683**

ALLEGATION:

The complainant reported that on September 9, 2014, the local EMS paramedics responded to a call from a local dialysis center that a patient arrived from the facility unconscious and unresponsive.

FINDINGS:

September 2014 Physicians' Orders documented the identified resident was on two oral anti-diabetic medications. On September 9, 2014, the resident's Medication Administration Record (MAR) documented the resident received the medications prior to leaving the facility to go to the dialysis center. The facility's record for the resident documented the resident had not eaten breakfast, dinner or a night time snack on September 8, 2014, and had not eaten breakfast the morning of September 9, 2014. On the morning of September 9, 2014, prior to being transported to the dialysis center, the resident was noted to require increased assistance to transfer from his bed to his wheelchair.

When interviewed by the surveyor during the investigation, the resident's family member stated that on the morning of September 9, 2014, when she/he arrived at the facility, the resident was exhibiting signs of altered consciousness and she talked with the licensed nurse (LN) responsible for the resident. The Certified Nurse Aide (CNA) who cared for the resident that morning and the van driver who transported the resident to dialysis were interviewed as well. Both staff identified that the resident was not his normal self, at the facility, and they notified the LN who was responsible for care of the resident.

The resident was taken to the dialysis center that morning. The dialysis center's records documented the resident arrived at the center slumped over and unresponsive. The ambulance service/EMS was contacted. When EMS arrived, a blood glucose was obtained, and the resident was found to be hypoglycemic at a level of 30 mg/dl. The resident was emergently treated by EMS and returned to his baseline level of consciousness.

The facility's administrator and Director of Nursing Services (DNS) were interviewed and acknowledged they were aware of the incident.

The facility's policy for hypoglycemia did not address residents on oral anti-diabetic medications.

The facility failed to identify, assess and treat a resident when the resident had a change in condition due to a low blood sugar. When the event was brought to the attention of the facility administration by EMS personnel, the facility failed to investigate and educate staff to ensure this type of event did not recur. This placed all residents in the facility with diabetes in immediate jeopardy (IJ). The facility was cited at F309 at the IJ level for failure to identify and care for hypoglycemia in a resident with diabetes; F490 for failure of the facility's administrator to follow through when notified of a critical event; F501 for failure of the Medical Director to implement care policies to manage residents with diabetes who were on oral diabetic medications; F520 for failure of the Quality Assurance process to identify and implement measures to ensure the safety of residents with diabetes; and, F514 for failure to maintain complete and accurate records.

CONCLUSIONS:
Substantiated. Federal and State deficiencies related to the allegation are cited.

Based on the findings of the complaint investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this complaint's 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 Lorene Kayser, L.S.W., Q.I.D.P. or David Scott, R.N., Supervisors, Long Term Care at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

Lorene Kayser

LORENE KAYSER, L.S.W., Q.I.D.P., Supervisor
Long Term Care

LKK/dmj