



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 1010 0002 0836 2144

October 17, 2013

Mark Teckmeyer, Administrator
Rexburg Care & Rehabilitation Center
660 South Second Street West
Rexburg, ID 83440-2300

Provider #: 135105

RE: October 2, 2013, Recertification, Complaint Investigation and State Licensure Survey
Report Cover Letter

Dear Mr. Teckmeyer:

On **October 2, 2013**, a Recertification, Complaint Investigation and State Licensure survey was conducted at Rexburg Care & Rehabilitation Center 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 to be an isolated deficiency that constitutes actual harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies, 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. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 3). **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**

Mark Teckmeyer, Administrator
October 17, 2013
Page 2 of 4

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 Form CMS-2567 and State Form, Statement of Deficiencies and Plan of Correction in the spaces provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **October 30, 2013**. Failure to submit an acceptable PoC by **October 30, 2013**, may result in the imposition of civil monetary penalties by **November 19, 2013**.

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

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. This monitoring will be reviewed at the follow-up survey, as part of the process to verify that the facility has corrected the deficient practice. Monitoring must be documented and retained for the follow-up survey. In your Plan of Correction, please be sure to include:
 - a. Specify by job title who will do the monitoring. It is important that the individual doing the monitoring has the appropriate experience and qualifications for the task. The monitoring cannot be completed by the individual(s) whose work is under review.
 - b. Frequency of the monitoring; i.e., weekly x 4, then q 2 weeks x 4, then monthly x 3. A plan for 'random' audits will not be accepted. Initial audits must be more frequent than monthly to meet the requirement for the follow-up.
 - c. Start date of the audits;
- Include dates when corrective action will be completed in column 5.

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

Mark Teckmeyer, Administrator
October 17, 2013
Page 3 of 4

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*.

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 **November 6, 2013 (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 **November 6, 2013**. A change in the seriousness of the deficiencies on **November 6, 2013**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **November 6, 2013** includes the following:

Denial of payment for new admissions effective **January 2, 2014**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, 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 **April 2, 2014**, if substantial compliance is not achieved by that time.

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

If you believe these deficiencies have been corrected, you may contact Loretta Todd, R.N. or Lorene Kayser, L.S.W., Q.M.R.P., 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. 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.

Mark Teckmeyer, Administrator
October 17, 2013
Page 4 of 4

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 **October 2, 2013** 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 noncompliance 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>

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

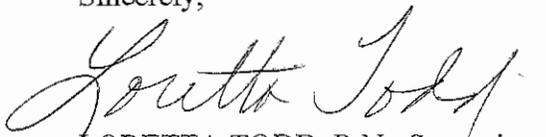
- BFS Letters (06/30/11)

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

This request must be received by **October 30, 2013**. If your request for informal dispute resolution is received after **October 30, 2013**, 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, please contact us at (208) 334-6626.

Sincerely,



LORETTA TODD, R.N., Supervisor
Long Term Care

LT/dmj
Enclosures

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

PRINTED: 10/16/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135105	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/02/2013
NAME OF PROVIDER OR SUPPLIER REXBURG CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 660 SOUTH 2ND ST WEST REXBURG, ID 83440	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following deficiencies were cited during the annual Federal recertification and complaint investigation survey of your facility. The surveyors entered the facility on 9-23-13 and exited the facility on 10-02-13. The surveyors conducting the survey were: Amy Jensen RN, Team Coordinator Nina Sanderson, LSW Survey Definitions: ADL = Activities of Daily Living AEB = As Exhibited By BMFS = Behavioral Monthly Flow Sheet BIMS = Brief Interview for Mental Status CAA = Care Area Assessment CNA = Certified Nurse Aide C/O = Complaint of DNS/DON = Director Nursing Services/Director of Nursing D/T = Due to Dx = Diagnosis Hx = History IDT = Interdisciplinary Team LN = Licensed Nurse MDS = Minimum Data Set assessment MAR = Medication Administration Record PRN = As Needed Pt = Patient Res = Resident R/T = Related To SNF = Skilled Nursing facility SSD = Social Services Designee TAR = Treatment Administration Record W/C = Wheelchair BID = Twice per day	F 000	“This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Rexburg Care & Rehabilitation Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency.”	
F 241	483.15(a) DIGNITY AND RESPECT OF	F 241		

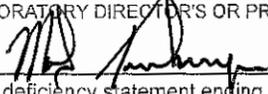
RECEIVED
OCT 31 2013

FACILITY STANDARDS

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

TITLE

(X6) DATE



NHA

10.30.13

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 241 SS=E	<p>Continued From page 1 INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and resident and staff interview, it was determined the facility did not provide care for residents in a manner and in an environment to enhance dignity and respect in recognition of their individuality. This was true for 4 of 9 residents (#s 3, 4, 6, and 7) sampled for dignity, and 3 of 7 residents in the resident group. The deficient practice had the potential to cause more than minimal harm when residents expressed feelings they were not being treated as individuals, as well as concern that they may sustain skin tears or bruises from facility-provided identification bracelets. Findings included:</p> <p>On 9/24/13 at 9:55 AM, Resident #5 was observed to be wearing a blue facility-provided wrist identification band on his right wrist. The band contained the resident's name, date of birth, and facility resident identification number. The band was approximately 1/2 " (inch) wide. Resident #5 was tugging at the band, trying to remove it. Resident #5 stated, "I hate this thing. I had to have them cut the tab (at the end of the band) off. It got tangled in my sleeves. Then I noticed the edges were sharp, so they tried to trim it down. I cut one of them off, and it made them mad so they (the facility) put another one on. They're a pain in the ever loving neck." On 10/1/13 at 8:50 AM, the surveyor re-visited the</p>	F 241	<p>F 241 On or before November 1st 2013, residents #3, 4, 5, 6 & 7 were interviewed by social service designee regarding use of identification bands and bands were removed as identified per resident's choice with care plan updated to reflect resident choice. Residents also assessed by social service designee on or before November 1st for psychosocial distress related to wearing the bands with no adverse effects.</p> <p>Other residents wearing identification bands not identified during survey were interviewed by social services designee on or before November 1st 2013. Resident's choices were honored and the care plans were updated.</p> <p>Nursing staff and admissions coordinator educated by director of nursing on or before November 1st 2013 to educate and then ask resident or family preference prior to placing band at time of admission.</p>		

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F 241	<p>Continued From page 2</p> <p>issue of the identification band with the resident. Resident #5 stated, "My feelings have not changed. Other than the wristband, I wouldn't change anything here. I hate this thing."</p> <p>On 9/24/13 at 2:00 PM, the residents participating in Resident Group stated, regarding the blue identification wrist bands:</p> <p>- "We only have to wear them until you guys (surveyors) leave. Then we can take them off again."</p> <p>- "They use it for identification when they are giving us our medications."</p> <p>- "We don't have a choice. They just put it on us."</p> <p>- "I'm not very happy about wearing it. It just confirms we are in an institution."</p> <p>- "It's for the new nurses so they know who we are."</p> <p>- "I heard the facility is selling out and needed to know who we were."</p> <p>- One resident rolled her eyes when asked if she wanted to wear the band, or had been given a choice.</p> <p>- On 10/1/13 between 9:00 and 10:00 AM, the residents participating in the Resident Group were visited individually about the wrist bands. The residents confirmed they still felt the same way about the wrist bands.</p> <p>On 9/30/13 at 4:25 PM, Resident #4 was observed sitting near the nurse's station on the west hallway. Resident #4 was observed to be wearing a blue identification band on her right wrist. Resident #4 was tugging at the wrist band, and stated, "They put this on me. They said it was for identification. I don't like it. They should know who I am by now. I shouldn't need identification. There's this little thing here (referring to the fastener on the band, which was a hard plastic</p>	F 241	<p>Beginning the week of November 4th, director of nursing or designee will review 3 admissions weekly to ensure resident's choice for identification and use of bracelet were maintained weekly for 4 weeks and then monthly for 2 months. Results to be discussed at monthly Performance Improvement Committee x 3 months. Director of Nursing responsible for follow up.</p>	11/14/13	

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F 241	Continued From page 3 snap type device approximately 1/2 " in size). See, put your finger under there. It hurts. What a pain in the butt." On 10/1/13 at 4:30 PM, the DNS was asked about the identification bands for the residents. The DNS stated she was aware of the resident objections to the bands, but the corporation operating the facility had determined they were necessary for the residents' safety, and did not create an institutional environment. The DNS stated she did not necessarily care for the identification bands any more than the residents did.	F 241			
F 312 SS=D	On 10/1/13 at 6:30 PM, the Administrator and DNS were informed of the surveyor's findings. The facility offered no further information. 483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident and staff interview, it was determined the facility did not ensure residents received adequate assistance for meal consumption and oral care. This was true for 2 of 6 residents (#s 4 and 5) sampled for ADL assistance. The deficient practice had the potential to cause more than minimal harm if residents experienced weight	F 312	F 312 Resident # 5 was reassessed for assistance with eating by director of nursing on or before November 1st 2013 and care plan updated as indicated by assessment to reflect resident's current status. Resident was assessed by social services designee on or before November 1st 2013 for any adverse psychosocial effects related to assistance offered at meals with no negative findings.		

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F 312	<p>Continued From page 4 loss or tooth decay. Findings included:</p> <p>1. Resident #5 was admitted to the facility on 11/24/12 with multiple diagnoses including left bimalleolar ankle fracture, diabetes, hypertension, and diverticulitis.</p> <p>Resident #5's most recent Quarterly MDS assessment, dated 7/9/13, documented: -BIMS of 9, indicating moderately impaired cognitive skills. -Extensive assistance of 1 for eating.</p> <p>Resident #5's care plan documented, in the focus areas of self-care deficit, "E/1 [extensive assistance of 1] [with] eating, bathing." Date initiated was 7/12/13.</p> <p>On 9/30/13, between 5:00 and 5:30 PM, Resident #5 was observed at the dinner meal, as follows (continuous observation): -5:00 PM, meal tray served. -5:05 PM, ADON at the table, cued Resident #5 to drink her chocolate milk, but no physical assistance offered or provided. -5:10 PM, the ADON stated, "[Resident #5], you're not eating." -5:30 PM, LN #2 attempted to assist Resident #5 with her meal, 30 minutes after it was served. -Resident #5 left the dining room without eating her meal or drinking her fluids.</p> <p>On 10/1/13, between 7:15 AM and 7:39 AM, Resident #5 was observed at the breakfast meal, as follows (continuous observation): -7:15 AM, Resident #5 was sitting at the table with her breakfast meal in front of her. She was facing the window of the room, with her eyes closed. She was not feeding herself her meal,</p>	F 312	<p>Resident # 4 oral cavity was reassessed by director of nursing on or before November 1st 2013 to ensure cleanliness and oral cares completed. Corrections made at time of assessment as indicated and care plan updated to reflect current assistance required. Resident was assessed by social services designee on or before November 1st 2013 for any adverse psychosocial effects related to buildup in mouth with no negative findings.</p> <p>A review of other residents requiring extensive assist with eating was performed on or before November 1st by director of nursing at meal time to ensure assistance was being offered. Updates in plan of care were made as indicated through review.</p> <p>A review of other residents requiring assistance with oral care was completed by director of nursing or designee on or before November 1st 2013 to ensure assistance offered and oral care complete before and after meals as indicated and updates to care plans were made as indicated through review.</p>		

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F 312	<p>Continued From page 5</p> <p>and did not indicate an awareness the meal was there.</p> <p>-7:26 AM, approached by CNA #3. Without sitting to assist Resident #5, CNA #3 asked the resident how her breakfast was. Resident #5 did not respond. CNA #3 sat at the table for approximately 20 seconds and offered Resident #5 encouragement to eat. Resident #5 fingered some of her food items, but did not eat. CNA #3 left the table to assist other residents. Once CNA #3 left the table, Resident #5 closed her eyes again, and did not touch her food.</p> <p>-7:31 AM, Resident #5 opened her eyes and began to finger her food. She did not eat, no staff were at the table, and no assistance was offered.</p> <p>-7:39 AM, CNA #3 was assisting residents at a table two tables away from Resident #5. From that location, CNA #3 stated loudly, "[Resident #5], do you need me to scoot you up closer to the table, or are you OK?"</p> <p>-Again, Resident #5 left the dining room having consumed only a minimal amount of her food and fluids.</p> <p>On 10/1/13 at 8:40 AM, the DNS was interviewed about assistance at meals for Resident #5. The DNS stated Resident #5 was at a "cueing" table, as opposed to a table where residents required assistance to eat. The DNS stated Resident #5, "does and can feed herself when she is motivated." The DNS was asked about the facility assessment and care plan, both of which documented Resident #5 required extensive assistance at meals. The DNS stated, "Some days she is an extensive assist, some days she is independent." The surveyor informed the DNS of the meal observations on 9/30/13 and 10/1/13. The DNS stated, "That's not OK."</p>	F 312	<p>Nursing staff educated regarding amount of assistance provided at meals and to update care plans as amount of assistance needed for meals changes by director of nursing on or before November 1st 2013 to ensure assistance being offered is per care plan.</p> <p>Nursing staff educated by Director of Nursing on or before November 1st 2013 to ensure oral care is provided twice daily and as needed and if residents are noted with buildup in their mouth including teeth, to assist residents with oral care at the time of findings.</p> <p>Beginning the week of November 4th 2013, 5 meals will be observed by director of nursing or designee to ensure plan of care reflects current resident status as to amount of assistance needed during meals and that resident needs are met weekly for 4 weeks and then monthly for 2 months. Results to be discussed at monthly Performance Improvement Committee x 3 months. Director of nursing responsible for follow up.</p>	

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F 312	<p>Continued From page 6</p> <p>On 10/1/13 at 6:30 PM, the Administrator and DNS were informed of the surveyor's findings. The facility offered no further information.</p> <p>2. Resident # 4 was admitted to the facility on 7/8/11 with multiple diagnoses which included dementia with behavioral disturbances.</p> <p>Resident #4's most recent Quarterly MDS, dated 8/9/13, documented: -BIMS of 8, indicating moderately impaired cognitive skills. -Extensive assistance of 1 for personal hygiene.</p> <p>Resident #4's care plan documented: -"[Resident #4] has her own teeth." Date initiated 8/7/11. -"Oral cares BID and PRN." Date initiated 8/7/11.</p> <p>On 9/30/13 at 4:25 PM, Resident #4 was observed sitting in her wheelchair near the west nurse's station. Resident #4 was calling out, repeatedly, "I need a toothbrush. Please." No staff were observed in the area. When approached by the surveyor, Resident #4 covered her mouth with her hand and stated, "Don't get too close, it's bad." Once the surveyor engaged Resident #4 in conversation, she removed her hand from her mouth. Her teeth were covered with a pasty white build-up, with a white gummy substance between on and between her teeth.</p> <p>On 9/30/13 at 4:50 PM, Resident #4 was observed in the dining room with her meal. The surveyor asked Resident #4 if she had had an opportunity to brush her teeth before the meal. Resident #4 stated, "No." The build-up was present in her mouth.</p>	F 312	<p>Beginning the week of November 4th 2013, a review of 3 residents will be performed by director of nursing or designee to ensure oral care provided and no substance left in mouth weekly for 4 weeks and then monthly for 2. Results to be discussed at monthly Performance Improvement Committee x 3 months. Director of Nursing responsible for follow up.</p>	11/14/13	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135105	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/02/2013
NAME OF PROVIDER OR SUPPLIER REXBURG CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 660 SOUTH 2ND ST WEST REXBURG, ID 83440		
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F 312	Continued From page 7 On 10/2/13 at 2:10 PM, the DNS was asked about oral care for Resident #4. The DNS stated, "Yes, I was told that wasn't done. I brushed her teeth myself this morning,"	F 312			
F 314 SS=G	On 10/2/13 at 4:30 PM, the Administrator and DNS were informed of the surveyor's findings. The facility offered no further information. 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 staff interview and record review, it was determined the facility did not ensure a resident who entered the facility without a pressure ulcer, remained free from pressure ulcers. This was true for 1 of 1 residents (Resident #5) sampled for pressure ulcers. Resident #5 was harmed when she developed a Suspected Deep Tissue Injury (SDTI) in the facility which later opened to a Stage III pressure ulcer. Findings included: Resident #5 was admitted to the facility on 11/24/12 with multiple diagnoses including left bimalleolar ankle fracture, diabetes, hypertension,	F 314	F 314 Resident # 5 skin and risk factors were reassessed by director of nursing on or before November 1st 2013, assessment revealed resident #5 skin remains intact with no noted open areas found. Care plan reviewed by Director of Nursing on or before November 1st 2013 with no required changes at this time, will continue to assess with intervention changes as needed.		

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F 314	<p>Continued From page 8 and diverticulitis.</p> <p>Resident #5's admission MDS assessment, dated 11/24/12, documented no pressure ulcers present.</p> <p>Resident #5's most recent quarterly MDS, dated 7/9/13, coded: *BIMS of 9, indicating moderately impaired cognitive skills. *Extensive assistance of 2 persons for bed mobility and transfers. *Extensive assistance of 1 person for wheelchair mobility. *Did not ambulate. *Unhealed Stage III pressure ulcer (PU), not present or present at a lesser stage on the previous assessment. *Skin and ulcer treatment of pressure reducing devices for bed and wheelchair, and ulcer care. *No turning or repositioning program.</p> <p>Resident # 5's care plan documented: *Alteration in skin integrity R/T [related to] SDTI to right heel, initiated on 3/12/13. Modified on 6/12/13 as a Stage III PU. *Float heels, initiated 3/12/13. *Podus boots on at all times, initiated 3/12/13. *Pressure reducing/relieving devices as ordered, initiated 3/12/13. [NOTE: The above items were all discontinued on 8/12/13, when the PU was documented as healed.] *Low air loss mattress with bolsters, initiated 4/23/13, discontinued 6/6/13. *Assist to turn and reposition as needed to promote comfort and skin integrity, initiated 11/26/12.</p>	F 314	<p>Other residents not identified had their skin condition reviewed by members of the nursing management team which include director of nursing, MDS Coordinator and the medical records licensed nurse on or before November 1st 2013 to ensure no other residents were noted with open area. No new areas were identified. Residents Braden scale were also reassessed and care plans and interventions including need to off load heels as applicable were updated according to risk factors, pertinent history, comorbidities and current clinical condition by members of the nurse management team on or before November 1st 2013.</p> <p>On or before November 1st 2013 nursing staff were reeducated by Director of Nursing regarding assessment, interventions and documentation which includes updating resident care plan related to skin breakdown and prevention as indicated by clinical assessment, pertinent history and changes of condition which includes floating heels and turning and repositioning.</p>	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 314	<p>Continued From page 9</p> <p>Resident #5's Physician's Orders documented: *11/24/12 - Low Air Loss (LAL) mattress with a bolster sheet. [NOTE: The LAL mattress was not noted on Resident #5's care plan until 4/23/13.] *3/11/13 - Float Heels, night shift, day shift, everyday. *3/11/13 - Podus Boots on at all times - night shift, day shift, everyday.</p> <p>Resident #5's Norton Plus Pressure Ulcer Scale form documented: [NOTE: The form documented a score of 10 and below indicated a high risk for pressure ulcers.]: *12/5/12, score of 6. *1/23/13, score of 5. *2/13/13, score of 5. *3/11/13, score of 9 [NOTE: This was the date the facility noted a SDTI. The score from this date indicated Resident #5 was at high risk of developing pressure ulcers, but at less risk than she had been on the previous assessment.] *4/3/13, score of 5. *5/1/13, score of 5. *6/4/13, score of 5.</p> <p>Resident #5's Interdisciplinary Progress Notes (PN's) documented: *1/30/13 at 12:30 PM, "Care team review - Resident completed ABT (antibiotic) for UTI..." * 2/6/13 at 6:30 PM, "Received critical creatinine value...MD notified..." *2/7/13 at 4:00 PM, "...New orders received for CMP (Complete Metabolic Panel) today and UA (urinalysis) [with] culture." *2/8/13 at 10:00 AM, "...refused to get up for breakfast..." *2/9/13 at 2:45 PM, "...has been medicated [with] Zofran X 1 for N&V [nausea and vomiting]. Emesis appears to be mostly bile..."</p>	F 314	<p>Beginning the week of November 4th 2013 Director of Nursing or designee will review 5 charts per week for residents at risk for skin breakdown to ensure interventions are care planned and in place based upon current clinical condition, pertinent history, comorbidities and risk factors weekly for 4 weeks and monthly for 2 months. Results to be discussed at monthly Performance Improvement Committee x 3 months. Director of Nursing responsible for follow up.</p>	11/14/13

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F 314	Continued From page 10 *2/9/13 at 3:00 PM, "Large amount liq[uid] brown emesis..." *2/9/13 at 2:30 PM, "Resident vomiting quite a lot pale in color family request for resident to be sent to the ER for evaluation. Ambulance called resident transported..." [NOTE: This was the order the entries appeared in Resident #5's record, even though this entry indicates the date and time was before the previous two entries.] *2/9/13 at 7:00 PM, "Resident returned from ER. IV [intravenous fluids] placed..." *2/11/13 at 2:00 PM, "Medicated for N/V this AM [and] helped..." *2/11/13 at 9:30 PM, "...Random crackles in [right] lower lobe...swelling in ankles and feet..." *2/13/13 at 11:30 AM, "Care team review - [weight] [down] average meal/fluid intakes [down]...Resident [complains of] N/V frequently. MD aware...Resident given IV fluids...Completed ABT for UTI...Uses LAL mattress...impaired mobility...Norton = 5 [high risk for PU development]...Continue current POC [plan of care]." *2/18/13 at 11:30 AM, "Res[ident] c/o N/V at 9:30 AM. Emesis X 1. Light green, small..." *2/18/13 at 8:30 PM, "Resident found with emesis on her face and clothing..." *2/20/13 at 11:30 AM, "Care team review - [weight] [up] slightly. Average meal/fluid intakes [down]. Fluids and meals encouraged..." *2/24/13 at 8:00 PM, "Resident c/o not feeling well but denies nausea and refuses medication for nausea..." *2/25/13 at 11:00 AM, "Care team review - [weight] down]. Continues [with] health shake. Will have MD review..." *3/6/13 at 2:00 PM, "Care team review - [weight] [down] average meal/fluid intakes [down]. Resident c/o N/V [at] times. Noted [with] critical	F 314			

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

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F 314	<p>Continued From page 11 labs, start IV fluids X 2 days..."</p> <p>*3/7/13 at 9:40 AM, "Resident has been very agitated. Refused IV started hitting staff..."</p> <p>*3/8/13 at 2:00 PM, "Staff reported that she had emesis X 2."</p> <p>*3/11/13 at 9:00 AM, "Care team review...Resident found this AM [with] SDTI to [right] heel..."</p> <p>Resident #5's Pressure Ulcer Documentation Forms documented: *SDTI to the right heel on 3/11/13, measuring 3.4 centimeters (cm) long X 2.8 cm wide. *The SDTI continued to be monitored as present on 3/16/13, 3/22/13, 3/30/13, 4/6/13, 4/14/13, 4/54/13, 4/27/13, 5/4/13, 5/11/13, 5/18/13, 5/25/13, 6/1/13, and 6/8/13. *In the column following the entry for 6/8/13 the form documented, "See new sheet now Stage III."</p> <p>Resident #5's Skin Integrity Report form documented: *In house acquired SDTI initially noted on 3/11/13, re-staged as a Stage III PU on 6/12/13 and healed on 8/12/13. *On 6/12/13, the PU was noted as 3 cm X 2.8 cm X 0.2 cm, with serous drainage present. *The Stage III PU was noted present on 6/12/13, 6/15/13, 6/25/13, 6/29/13, 7/10/13, 7/13/13, 7/10/13, 7/27/13, 8/2/13, and 8/9/13.</p> <p>Resident #5's Nursing Home Visit forms (Physician's Progress Notes) documented: *1/15/13, "[Resident #5] seems to be declining...She is comfortable and the nurses have no real concerns about her...No new medical issues are reported..."</p> <p>*2/1/13, "She is confined to a wheelchair and unable to walk. I don't think she is going to</p>	F 314			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 314	<p>Continued From page 12</p> <p>improve dramatically...No new medical issues reported. The patient seems to be stable..."</p> <p>*3/12/13, "The nursing staff has noticed some swelling on the right jaw for the past 12 hours...No new medical issues are reported. The patient seems stable...Extremities: No cyanosis or clubbing. Minimal edema..." [NOTE: This entry was made the day after the facility first documented the SDTI. However, the physician did not address the SDTI in the progress note.]</p> <p>*4/16/13, "...No new medical issues are reported..."</p> <p>*5/14/13, "...No new medical issues are reported..."</p> <p>*6/25/13, "...No new medical issues are reported..." [NOTE: This is the first entry from Resident #5's physician after the SDTI was re-staged as a Stage III PU. 13 days had passed since the PU was staged. The physician did not address the PU in the progress note.]</p> <p>*7/16/13, "...No new medical issues are reported..."</p> <p>On 10/1/13 at 8:40 AM, the DNS was asked about the development of the SDTI and subsequent Stage III PU for Resident #5. The DNS stated when Resident #5 was originally admitted to the facility in November 2012, the facility had implemented the LAL mattress as an intervention, due to the resident being assessed as high risk of developing pressure ulcers. The DNS stated beginning in February 2012, Resident #5 began to develop nausea and began vomiting, "every day, every meal, all the time." Resident #5 was eventually diagnosed with gastroparesis and successfully treated, but not before she was sick enough to require IV fluids. The DNS stated even when Resident #5 was very sick, the facility still got her out of her bed and into her wheelchair for</p>	F 314		

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

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F 314	<p>Continued From page 13</p> <p>meals 3 to 4 times per day, as they felt she was too much of an aspiration risk to be left unattended in her bed to eat meals. The DNS stated Resident #5's heels had been floated from the time of admission, and Podus boots placed as soon as the SDTI was found. [NOTE: Resident #5's care plan did not document her heels were to be floated until 3/12/13, the day after the SDTI was found.] The DNS stated the facility felt the SDTI was related to Resident #5's nutritional status, as there was, "no identifiable trauma" to the resident's heel. The DNS stated when Resident #5's gastroparesis had been successfully treated, her nausea and vomiting resolved, and the PU to her heel eventually healed. The DNS stated she would further research what interventions had been in place to protect Resident #5's heels, both in bed and in her wheelchair, prior to the development of the SDTI.</p> <p>On 10/1/13 at 2:25 PM, the DNS reported back to the surveyor with her findings. The DNS stated Resident #5 was noted to be at increased risk for PUs upon admission, so the facility implemented a LAL mattress. The DNS stated the facility continued to repeat the Norton PU scale monthly due to the resident's increased risk at developing PU's. After the SDTI developed, the facility implemented the approaches of using the Podus boots and floating the resident's heels in bed. The DNS re-iterated Resident #5's nutritional status was the root cause of the SDTI due to decreased meal intakes and low albumin levels in February 2013. The DNS stated the facility implemented nutritional interventions and involved the MD in the situation. [NOTE: MD progress notes for this period of time do not address either Resident #5's nutritional status, nor the SDTI to her right heel.]</p>	F 314		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 314	<p>Continued From page 14</p> <p>The DNS stated the facility noticed no signs of skin problems, such as mushy or boggy heels, prior to the development of the SDTI. The DNS stated, "It was not there one week, then there the next." The DNS stated the facility did not feel additional interventions for the prevention of skin breakdown were warranted prior to the development of the SDTI due to the LAL mattress, and the fact that Resident #5 was eating better and her nutritional status was improving as evidenced by increased intakes.</p> <p>On 10/1/13 at 2:25 PM, the DNS was asked about the facility's decision to discontinue Resident #5's LAL mattress on 6/6/13, and the conversion of the SDTI to a Stage III PU just 6 days later. The DNS stated Resident #5 had slid off the LAL mattress onto the floor on 6/5/13, so the facility felt the mattress was no longer the safest measure for Resident #5. The DNS stated, "But one has nothing to do with the other. We had the Podus boots on her. The LAL mattress in addition to that did not help her heels at all, but was only preventive for other areas of her skin that might break down."</p> <p>On 10/2/13 at 9:25 AM, the DNS was asked again about care plan interventions for prevention of skin breakdown in conjunction with Resident #5's illness, such as a more aggressive repositioning schedule, pressure relief for her heels when she was in her wheelchair, or floating her heels while in bed. The DNS stated everyone had a care plan for the same turning schedule, which was every 2 hours and as needed. The DNS stated that turning schedule should have been adequate for Resident #5, even if she needed to be re-positioned more frequently, due to the "as needed" clause. The DNS stated</p>	F 314		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 314	<p>Continued From page 15</p> <p>Resident #5's heels were floated from the time she was admitted. When asked why it was only added to Resident #5's care plan on 3/12/13, the DNS stated, "That's when we noticed the PU", and that she would research further. The DNS was asked again what kind of pressure relief was in place for Resident #5's heels when she was sitting in her wheelchair, prior to the discovery of the SDTI. The DNS stated, "I'm not sure. I'll have to check."</p> <p>On 10/2/13 at 3:05 PM, the DNS returned to the surveyor with Resident #5's care plan for skin integrity from 11/24/12 through 3/12/13. There were no new interventions documented for Resident #5's skin protection during that time. The DNS stated, "I don't think we harmed her. We had her on an air mattress from the time of admission. I really didn't think the N/V would go on for 4 weeks. We were concentrating on her nutrition. That was our primary concern."</p> <p>While the facility did recognize Resident #5's illness, and its potential impact on her nutritional status, they did not apply that knowledge to other areas of her declining status. The facility did not implement new measures to protect her skin, such as heel protection when she was in her wheelchair, offloading of her heels in bed, or a more aggressive turning schedule. Resident #5 was harmed when she developed a SDTI to her right heel during an acute illness, which later converted to a Stage III PU.</p> <p>On 10/2/13 at 5:00 PM, the Administrator and DNS were informed of these findings. The facility offered no further information to resolve the concern.</p>	F 314		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 323 F 323 SS=D	<p>Continued From page 16 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident 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, resident and staff interview, and record review, it was determined the facility did not ensure adequate supervision to prevent falls. This was true for 1 of 9 residents (Resident #3) sampled for falls. The deficient practice had the potential to cause more than minimal harm when Resident #3 continued to fall after the facility failed to implement interventions deemed necessary to prevent falls. Findings included:</p> <p>Resident #3 was admitted to the facility on 12/22/12 with multiple diagnoses which included diabetes mellitus type 2, dementia, atrial fibrillation with anticoagulation, and restless leg syndrome.</p> <p>Resident #3's most recent Quarterly MDS assessment, dated 9/18/13, documented: -BIMS of 14, indicating minimal cognitive deficit. -Extensive assistance of 2 for bed mobility and transfers. -Did not ambulate. -Extensive assistance of 1 for wheelchair mobility. -Unsteady moving from a sitting to standing</p>	F 323 F 323	<p>F 323 Resident #3 was assessed by Director of Nursing on or before November 1st 2013 for fall risk and interventions, updates in plan of care were made as indicated through review.</p> <p>A review of residents determined to be high risk as identified on fall risk assessment were made by Director of Nursing or designee on or before November 1st 2013 to ensure interventions were implemented as stated on care plan. Care plans updated at time of review as applicable.</p> <p>Nursing staff reeducated by Director of Nursing on or before November 1st 2013 to ensure interventions are implemented as stated on care plan and new interventions are updated as needed to reflect residents current status and plan.</p>	

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F 323	<p>Continued From page 17</p> <p>position, transferring on and off the toilet, and for other surface to surface transfers. -Has had 2 or more falls with minor injuries since the last MDS assessment.</p> <p>Resident #3's care plan documented under the focus area of "Risk for Falls": -"Resident to wear non-slip footwear." Initiated 12/24/12. -"Have commonly used articles within easy reach." Initiated 12/24/12. -"Ensure all items in reach when in room." Initiated 5/21/13</p> <p>Resident #3's care plan documented under the focus area of, "Alteration in Skin Integrity" regarding the presence of diabetic foot ulcers, "No sneakers or tight shoes, may wear slippers." Initiated 7/11/13. [NOTE: Please see F 328 as it pertains to diabetic foot care.]</p> <p>Facility Incident and Accident (I/A) forms for Resident #3 documented: -5/18/13 at 10:45 AM. Fall from bed, while attempting to reach the ringing telephone. Wearing only socks on his feet. The "Recommendation to prevent further falls" area of the form documented, "Staff educated to ensure residents have all personal items in reach when in bed." -6/17/13 at 3:30 PM. Fall from wheelchair, in his room, while reaching for his table. The "Recommendations to prevent further falls" area of the form documented, "Alarm to bed and chair." The "Narrative conclusion of root cause" area of the form documented, "Staff to ensure items in reach when in room." -8/18/13 at 10:30 AM, fall from his wheelchair, with a skin tear. Wearing no shoes or slippers,</p>	F 323	<p>Beginning the week of November 4th 2013, Director of Nursing or designee will review 5 residents at risk for falls per week to ensure interventions are added and implemented as indicated weekly for 4 weeks and monthly for 2 months. Results to be discussed at monthly Performance Improvement Committee x 3 months. Director of nursing responsible for follow up.</p>	11/14/13

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

PRINTED: 10/16/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135105	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/02/2013
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F 323	<p>Continued From page 18 but only socks. -8/25/13 at 10:30 AM, fall from his wheelchair, with an abrasion. Wearing no shoes or slippers, but only socks.</p> <p>Resident #3 was observed to be wearing cotton socks only (no shoes, gripper socks, or slippers) on the following occasions: -9/24/13 at 4:50 PM, sitting in his wheelchair at the dinner meal. -9/30/13 at 5:00 PM, sitting in his wheelchair at the dinner meal. -10/1/13 at 9:15 AM, sitting in his room in his wheelchair, dozing with the TV on.</p> <p>On 10/1/13 at 4:30 PM, the DNS was asked about Resident #3's falls, and repetitive care plan and post-fall interventions to keep personal items in reach. The DNS stated care plan and fall interventions were kept in a communication book for the staff, but it was likely not read every day. The DNS stated she thought the intervention should also be on the care card (Kardex) which the CNA's used to guide the care provided to the resident. As the DNS and surveyor left the room to review the care card, Resident #3 was noted to be sitting in the common area outside the activity room. Resident #3 was sitting in his wheelchair with only cotton socks on his feet. The DNS was asked if this was appropriate footwear, given Resident #3's history of falls. The DNS stated, "Oh. Yes. Well, I was thinking of the sores (diabetic foot ulcers). I didn't even think about his footwear related to his falls." The DNS was asked if Resident #3 could have non-skid socks or slippers. The DNS stated, "Oh, yes." The DNS was not certain if Resident #3 had ever been assessed for diabetic shoes, but stated she would look into it. [NOTE: Please see F 328 as it</p>	F 323		

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

PRINTED: 10/16/2013
FORM APPROVED
OMB NO. 0938-0391

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F 323	Continued From page 19 pertains to diabetic foot care.] Together the DNS and the surveyor reviewed Resident #3's Kardex. The Kardex included hand-written notations for, "No tight socks/shoes" and, "high fall risk." However, there was no indication about ensuring Resident #3's personal items were in reach, nor suggestions such as footwear other than cotton socks which might be appropriate for this resident.	F 323		
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, interview, and record review, it was determined the facility did not ensure residents received proper services regarding diabetic foot care. This was true for 1 of 2 residents (#3) sampled for diabetic foot care. The deficient practice had the potential to cause	F 328	F328 Resident # 3 was assessed by Director of Nursing on or before November 1st 2013 with no s/s of adverse effect noted. Resident physician and family made aware with orders obtained for podiatry follow up. Resident #3 will be seen by the podiatrist on 11/1/13 and follow up will be completed as ordered.	

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

PRINTED: 10/16/2013
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F 328	<p>Continued From page 20</p> <p>more than minimal harm when a resident at risk for falls, with diabetic foot ulcers, was not assessed for diabetic shoes. Findings included:</p> <p>Resident #3 was admitted to the facility on 12/22/12 with multiple diagnoses which included diabetes mellitus type 2, dementia, atrial fibrillation with anticoagulation, and restless leg syndrome.</p> <p>Resident #3's Admission History and Physical from the acute care hospital, dated 12/12/12, documented, "The chart indicated there were wounds on the feet. I found none. They must all be healed."</p> <p>Resident #3's most recent Quarterly MDS assessment, dated 9/18/13, documented: -BIMS of 14, indicating minimal cognitive deficit. -Extensive assistance of 2 for bed mobility and transfers. -Did not ambulate. -Extensive assistance of 1 for wheelchair mobility. -Unsteady moving from a sitting to standing position, transferring on and off the toilet, and for other surface to surface transfers. -Has had 2 or more falls with minor injuries since the last MDS assessment. -Diabetic foot ulcers present, with dressings in place.</p> <p>Resident #3's care plan documented under the focus area of, "Alteration in Skin Integrity" regarding the presence of diabetic foot ulcers, "No sneakers or tight shoes, may wear slippers." Initiated 7/11/13.</p> <p>Resident #3's Skin Integrity Report forms documented:</p>	F 328	<p>Residents with a diagnosis of diabetes will be reviewed by the Director of Nursing or designee on or before November 1st 2013 for diabetic footwear. Physician and residents and/or family made aware of findings with Podiatry referrals completed as needed.</p> <p>Social Services staff was reeducated by the Director of Nursing on or before November 1st 2013 for obtaining referrals for diabetic footwear for residents with diabetes in a timely manner regardless of payer source if physician, resident and family approves.</p> <p>Beginning the week of 11/4/13 an audit of new admissions by the Director of Nursing to ensure that diabetic footwear is offered to residents with diabetes with referrals as needed. These audits will be completed weekly X4 weeks and then monthly X2 months. The results of these audits will be reported to the Performance Improvement Committee for review monthly X3 months. The Director of Nursing is responsible for monitoring and follow up.</p>	11/14/13

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

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OMB NO. 0938-0391

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F 328	<p>Continued From page 21</p> <p>-7/7/13, a diabetic foot ulcer to the left lateral foot, 1 centimeter (cm) long X 1 cm wide X 0.2 cm deep. The facility continued to document on the wound, with the most recent assessment 9/23/13 as 0.6 cm X 1.3 cm X 0.2 cm.</p> <p>-9/2/13, a diabetic foot ulcer to the right lateral metatarsal, 0.2 cm X 0.3 cm X .02 cm. The facility continued to document on the wound, with the most recent assessment 9/23/13 as 0.3 cm X 0.5 cm X 0.2 cm.</p> <p>Resident #3 was observed to be wearing cotton socks only (no shoes, gripper socks, or slippers) on the following occasions:</p> <p>-9/24/13 at 4:50 PM, sitting in his wheelchair at the dinner meal.</p> <p>-9/30/13 at 5:00 PM, sitting in his wheelchair at the dinner meal.</p> <p>-10/1/13 at 9:15 AM, sitting in his room in his wheelchair, dozing with the TV on.</p> <p>On 10/1/13 at 4:30 PM, the DNS and the surveyor observed Resident #3 sitting in the common area outside the activity room. Resident #3 was sitting in his wheelchair with only cotton socks on his feet. The DNS was asked if this was appropriate footwear, given Resident #3's history of falls. The DNS stated, "Oh. Yes. Well, I was thinking of the sores (diabetic foot ulcers). I didn't even think about his footwear related to his falls." The DNS was asked if Resident #3 could have non-skid socks or slippers. The DNS stated, "Oh, yes." The DNS was not certain if Resident #3 had ever been assessed for diabetic shoes, but stated she would look into it.</p> <p>On 10/1/13 at 6:35 PM, the DNS reported back to the surveyor regarding diabetic shoes for Resident #3. The DNS stated, "An evaluation did</p>	F 328		

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

PRINTED: 10/16/2013
FORM APPROVED
OMB NO. 0938-0391

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F 328	Continued From page 22 not happen yet. [Resident #3] was here under his Medicare A benefit. We were waiting for him to come off of Medicare part A so we could bill Medicare part B for his shoes (rather than the facility paying for the shoes, as would be required for a resident receiving Medicare part A in a skilled nursing facility). He is on the schedule to be seen (by the podiatrist) now that he is no longer on (Medicare) part A." On 10/2/13 at 9:05 AM, the DNS and SSD re-approached the surveyor regarding diabetic shoes for Resident #3. The SSD stated she had called Resident #3's wife that morning, and Resident #3's wife reported the resident had tried diabetic shoes in the past, but he did not like them and would not wear them. The SSD stated Resident #3 had been placed on the list to be seen by the podiatrist, but could not say why the facility had not previously investigated Resident #3's history with the use of diabetic footwear. [NOTE: Resident #3's H&P at the time of his admission on 12/22/12 noted a history of foot ulcers. Resident #3 was noted in the facility with diabetic foot ulcers on 7/7/13. A total of 217 days had elapsed from the time of his admission, and 87 days since Resident #3 was first noted with a diabetic foot ulcer, to the time the facility investigated the history of using diabetic shoes.]	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	F 329		

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

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F 329	<p>Continued From page 23</p> <p>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.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on resident/staff interview and record review it was determined the facility failed to ensure unnecessary medications were not administered to a resident without clinical indications for use. This was true for 1 of 6 sampled residents (#6). This deficient practice had the potential for more than minimal harm if the resident fell because he was drowsy, confused, or oversedated. Findings include:</p> <p>Resident #6 was admitted to the facility on 8/23/13 and readmitted on 8/30/13 with multiple diagnoses to include, fall with fracture,</p>	F 329	<p>F329</p> <p>Resident #6 was assessed by the Social Services Designee/ licensed nurse on or before November 1st 2013 for anxiety. Findings along with documentation found in resident #6's medical record were reviewed by the IDT. Assessment findings, IDT recommendations, and current medication regime was reviewed with Resident #6 physician with orders received to discontinue the resident anxiety medication, care plan updated to reflect changes. Resident #6's plan of care was updated by the Social Services Designee on or before 11/1/13 to include non-pharmacological interventions for episodes of anxiety.</p> <p>A review of residents with nonscheduled antianxiety medication was completed by the Social Services Designee/ licensed nurse on or before November 1st 2013 to ensure that antianxiety use is justified and to ensure that non pharmacological interventions are included in the plan of care.</p>	

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

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F 329	<p>Continued From page 24</p> <p>pancreatitis, muscle weakness, and post traumatic seizure.</p> <p>The Resident's Admission MDS, dated 8/26/13, coded in part the following: * Ability to understand others and to make self understood. * STM (short term memory) LTM (long term memory), "OK" and independent with daily decision making. * Was coded "Behavior not present," for the following, Inattention, disorganized thinking, altered level of conscious, and psychomotor retardation.</p> <p>The Resident's Behavioral care plan documented the following: * Focus area, dated 9/6/13, "Resident #6 states he has a hx (history) of panic attacks where he gets real fidgety and restless, usually when he went to church or is around a large group of people." * Interventions, dated 9/6/13, "Administer Ativan per order. Track behaviors on behavior tracking sheet."</p> <p>The Resident's All Active Orders for September 2013 (Physician's Orders), documented the following orders: * Ativan (Lorazepam) 1 MG Tablet by mouth (Oral) - PRN (as needed): Q 6 hours (every six hours) for anxiety OR * Ativan (Lorazepam) 2 MG Tablet by mouth (Oral) - PRN (as needed); Q 6 hours (every six hours) for anxiety.</p> <p>A facility provided document, "Behavioral Monthly Flow Sheet, September 2013," documented the following:</p>	F 329	<p>Licensed nurses were educated by director of nursing on or before November 1st 2013 related to indications for use of antianxiety medications and non-pharmacological interventions.</p> <p>Beginning the week of November 4th 2013 an audit of 3 residents nonscheduled antianxiety medication were reviewed by the Director of Nursing to ensure that antianxiety medication use is justified as evidenced by documented specific s/s of anxiety and that non-pharmacologic interventions are included in the plan of care weekly X4 weeks and then monthly X2 months. The results of these audits will be reported to the Performance Improvement Committee x 3 months. The Director of Nursing is responsible for monitoring and follow up.</p>	11/14/13

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

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F 329	<p>Continued From page 25</p> <p>* 9/2/13 through 9/5/13 on day shift, Resident #6 had "0" episodes of anxiety, * 9/5/13, 9/6/13, and 9/9/13 on evening shift, Resident #6 had "0" episodes of anxiety, * 9/13/13 on night shift, Resident #6 had "0" episodes of anxiety.</p> <p>A facility provided document, "Medication Administration Record" (MAR), for September 2013, documented the following: * On 9/2/13 at 7:00 a.m., 9/3/13 at 7:15 a.m., 9/4/13 at 7:30 a.m., and 9/5/13 at 10:30 a.m., Resident #6 received Ativan 1 mg by mouth for "anxiety," * On 9/5/13 at 5:00 p.m., Resident #6 received Ativan 2 mg by mouth, 9/6/13 at 8:30 p.m. the Resident received Ativan 1 mg by mouth, and 9/9/13 at 6:00 p.m., Resident #6 received Ativan 2 mg by mouth for "anxiety."</p> <p>NOTE: Resident #6's Behavioral Monthly Flow Sheet (BMFS) documented the resident had "0" episodes of anxiety on multiple days during multiple shifts, however the facility medicated him anyway. In addition, the BMFS did not document what the signs and symptoms of anxiety were for the Resident, nor did the BMFS include non-pharmacological interventions tried prior to the use of the Ativan.</p> <p>Resident #6's "Interdisciplinary Progress Notes" (IPN) documented the following: * 9/2/13 at 9:25 a.m., "anxiety noted ativan helpful," * 9/4/13 at 8:00 p.m., "...was very upset he couldn't have a B.M. [bowel movement] - was given [two] Ativan p.o. [by mouth] for [increased] anxiety,"</p>	F 329			

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

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FORM APPROVED
OMB NO. 0938-0391

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F 329	Continued From page 26 NOTE: The first time anxiety was documented, by the facility for Resident #6 was on 9/2/13 and did not include the signs and symptoms observed by staff, nor did it include non-pharmacological interventions attempted prior to the Ativan being administered. In addition, it is not an indication for use to administer Ativan to the resident because he could not have a bowel movement. On 10/1/13 at 4:50 p.m. the DNS and SSD were informed and interviewed related to the above findings. The surveyor asked the DNS and SSD what Resident #6 looked like when he was anxious. The SSD said, " the Resident's eyes become glassy, see it in his face, and [the resident] will shift his weight whether he is sitting or standing." The DNS and SSD were asked at what point does the anxiety progress to the need for pharmacological interventions. The DNS and SSD stated, "We cannot say at what point it progresses, you will have to ask the nurse."The surveyor asked the DNS if it was ok to give Ativan to a resident who was upset about not having a bowel movement. The DNS said it was not "ok." The surveyor asked if it was ok to give Ativan when the behavior monitor sheet documented "0" episodes of anxiety. The DNS and SSD both said that was not ok. No additional information was provided by the facility.	F 329			
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by:	F 333			

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

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F 333	<p>Continued From page 27</p> <p>Based on staff interview and medical record review it was determined the facility failed to ensure a resident was free from any significant medication errors. This was true for 1 of 9 (#6) sampled residents. This deficient practice had the potential for more than minimal harm if the resident fell because he was drowsy, confused, or oversedated. Findings include:</p> <p>Resident #6 was admitted to the facility on 8/23/13 and readmitted on 8/30/13 with multiple diagnoses to include, fall with fracture, pancreatitis, muscle weakness, and post traumatic seizure.</p> <p>Resident #6's, "All Active Orders for September 2013" included the following orders: * "Ativan (Lorazepam) 1 MG Tablet By mouth (Oral) - PRN (as needed) Q (every) 6 hours, OR" * "Ativan (Lorazepam) 2 MG Tablet By mouth (Oral) - PRN (as needed) Q (every) 6 hours."</p> <p>Resident #6's Medication Administration Record (MAR) documented the following: * On 9/1/13 at 9:00 p.m. Ativan 2 mg was given for anxiety, * On 9/1/13 at 11:00 p.m. Ativan 2 mg was given for anxiety, * On 9/3/13 at 6:30 p.m. Ativan 2 mg was given for anxiety, * On 9/3/13 at 10:30 p.m. Ativan 2 mg was given for anxiety.</p> <p>NOTE: The physician's order clearly indicated there was to be 6 hours between doses. On 9/1/13 there was only 2 hours between the first and second dose and on 9/3/13 there was only 4 hours between the first and second dose.</p>	F 333	<p>F333</p> <p>Resident #6 was assessed by the Director of Nursing on or before November 1st 2013 with no noted increased sedation or other adverse effects noted.</p> <p>A review of the MAR's for the last 30 days was completed by the Director of Nursing on or before November 1st 2013 to ensure that medication was administered as ordered. No further errors were identified.</p> <p>Licensed staff was reeducated by the Director of Nursing on or before November 1st 2013 on the 6 rights of medication administration to include accurate documentation and following physician orders.</p>	

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

PRINTED: 10/16/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135105	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/02/2013	
NAME OF PROVIDER OR SUPPLIER REXBURG CARE & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 660 SOUTH 2ND ST WEST REXBURG, ID 83440		
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F 333 F 431 SS=D	<p>Continued From page 28</p> <p>On 10/1/13 at 4:50 p.m., the DNS and SSD were informed and interviewed about the potential medication error. The DNS reviewed the MAR and said there was only two hours between doses and she wondered if the Ativan was given on 9/2/13 and mistakenly documented on 9/3/13. No further information was provided.</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>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.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit</p>	F 333 F 431	<p>Beginning the week on November 4th 2013 an audit of 5 residents MARS will be completed by the Director of Nursing to ensure that medications were administered as ordered weekly X4 weeks and then monthly X2 months. The results to be discussed at monthly Performance Improvement Committee for X3 months. The Director of Nursing is responsible for monitoring and follow up.</p>	11/14/13

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F 431	<p>Continued From page 29</p> <p>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, staff interview, and record review, it was determined the facility failed to ensure opened insulin was not expired or outdated and to ensure a system was in place to reconcile loss or diversion of controlled medications. This was true for 2 of 2 Insulin Pens in the 100 hall medication cart and 1 of 9 sampled residents (#1). This failed practice created the potential for residents to receive expired insulin and for increased pain/discomfort if a resident did not have her Fentanyl patch. Findings include:</p> <p>1. On 10/1/13 at 11:40 a.m., during an inspection of the 100 hall medication cart, the surveyor identified two insulin pens without open dates. LN #1 was asked what dates the insulin pens were opened. LN #1 looked at the Lantus Pen and Novolog pen and said, " I have no idea when the pens were opened, the dates should be on them." LN #1 identified she did not open the Lantus Solostar pen, but proceeded to write the date 9/28/13 on the Lantus pen. The surveyor asked her why she wrote the date on the pen if she didn't open it and LN #1 said because the pharmacy sent the pen on 9/27/13.</p> <p>NOTE: The medication inserts for Lantus and Novolog under storage and handling documented that 28 days after being opened the insulin should be discarded. Additionally, the insert documented, "Using Lantus and/or Novolog after 28 days may</p>	F 431	<p>F431</p> <p>Resident #1 was assessed with no s/s of adverse effect noted. The undated insulin pens were disposed of by the licensed nurse on October 3rd 2013.</p> <p>Resident not identified in sample list was assessed by licensed nurse on October 28th 2013 with no adverse effects noted from use of pen.</p> <p>Resident #5 was assessed by the licensed nurse on October 28th 2013 with no pain or adverse effect noted. Statement from licensed nurse did reveal she investigated missing patch. Licensed nurse educated to inform Director of Nursing when patches are missing.</p> <p>Resident #5's current supply of Fentanyl patches were counted by the Director of Nursing and licensed nurse with all medications accounted for on October 28th 2013.</p> <p>A review of residents with insulin pens was completed by the Director of Nursing on October 28th 2013 with no current insulin pens in use.</p>	

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F 431	<p>Continued From page 30</p> <p>result in decreased strength of the insulin and can potentially increase residents risk for elevated blood sugars."</p> <p>On 10/1/13 at 3:05 p.m. the DNS was asked if it was a standard of practice to use insulin pens that do not have open dates on them or if a nurse that didn't open the pen should write the date opened on the pen if found opened. The DNS said the nurse should not use an insulin pen without the date opened on it or to date an insulin pen if she was not the one that opened it.</p> <p>2. Resident #5 was admitted to the facility on 11/24/12 with multiple diagnoses to include, left bimalleolar ankle fracture, backache, generalized pain, pain in joint/pelvic region/thigh, and osteoarthritis.</p> <p>The Centers for Medicare & Medicaid Services informational letter S&C: 13-02-NH dated 11/2/12, included the following guidance for providers related to Fentanyl Patches: "The facility's policies must address safe and secure storage, limited access and reconciliation of controlled substances in order to minimize loss or diversion, and provide for safe handling, distribution and disposition of medications."</p> <p>Note: On 10/1/13 the surveyors requested the policy and procedure for the disposition of Fentanyl patches consistent with applicable state and federal requirements, and standards of practice. The facility provided no further information.</p> <p>Resident #5's handwritten physician's order dated 2/7/13 documented the following order, "Fentanyl 100 mcg patch apply every 72 hrs."</p>	F 431	<p>Rounds were completed by the Director of Nursing to ensure that resident with fentanyl patches ordered had patches in place as ordered on 10/28/13 with no issues identified.</p> <p>Nursing staff educated by Director of Nursing on or before November 1st 2013 to ensure placement of patches and investigation of misplaces patches.</p> <p>Nursing staff educated by Director of Nursing on or before November 1st 2013 to ensure insulin pens are dated per manufacture recommendations.</p> <p>Beginning the week of November 4th 2013 an audit of 3 residents with insulin pens will be audited for dates, and 3 residents with medicated patches will be audited for placement will be completed by the Director of Nursing weekly X 4 weeks and then monthly X2 months. The results of these audits will be reported to the Performance Improvement Committee for review monthly X3 months. The Director of Nursing is responsible for monitoring and follow up.</p>	11/14/13

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F 431	<p>Continued From page 31</p> <p>A facility provided document, "Interdisciplinary Progress Notes" (IPN) dated 8/30/13, documented, "Did not see Fentanyl patch on pt [patient], crying in pain. New dose of Fentanyl applied to [right] side of chest."</p> <p>NOTE: The IPN did not include any further documentation related to the missing Fentanyl patch, nor did the facility conduct an investigation to determine what happened to the missing Fentanyl patch.</p> <p>On 10/2/13 at 2:10 p.m., LN #2 and the DNS were interviewed regarding the missing Fentanyl patch on 8/30/13 for Resident #5. LN #2 told the surveyors Resident #5 was crying during a shower and when the LN came into the shower room to check the resident's skin LN #2 noticed that the resident did not have her patch on. The LN went to the MAR to confirm placement of the patch on the right or left chest, returned to the resident and the patch was not there. LN #2 said the sheets had been changed, the bed was searched, the shower room was searched and the patch was not found. No further information was provided by the DNS.</p>	F 431		

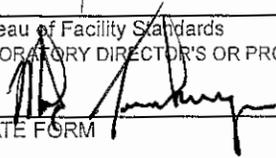
Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001640	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 10/02/2013
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NAME OF PROVIDER OR SUPPLIER REXBURG CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 660 SOUTH 2ND ST WEST REXBURG, ID 83440
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C 000	<p>16.03.02 INITIAL COMMENTS</p> <p>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.</p> <p>The following deficiencies were cited during the State licensure survey of your facility.</p> <p>The surveyors conducting the survey were:</p> <p>Amy Jensen, RN, Team Coordinator Nina Sanderson, LSW</p>	C 000		
C 125	<p>02.100,03,c,ix Treated with Respect/Dignity</p> <p>ix. Is treated with consideration, respect and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs;</p> <p>This Rule is not met as evidenced by: Please see F 241 as it pertains to resident dignity.</p>	C 125	<p>C 125 Refer to F 241</p>	
C 784	<p>02.200,03,b Resident Needs Identified</p> <p>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:</p> <p>This Rule is not met as evidenced by: Please see F 312 as it pertains to ADL assistance, and diabetic foot care.</p>	C 784	<p>C 784 Refer to F 312</p> <p>RECEIVED OCT 31 2013 FACILITY STANDARDS</p>	
C 789	<p>02.200,03,b,v Prevention of Decubitus</p>	C 789		

Bureau of Facility Standards
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE



TITLE
NHA

(X6) DATE

10.30.13

Bureau of Facility Standards

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C 789	Continued From page 1 v. Prevention of decubitus ulcers or deformities or treatment thereof, if needed, including, but not limited to, changing position every two (2) hours when confined to bed or wheelchair and opportunity for exercise to promote circulation; This Rule is not met as evidenced by: Please see F 314 as it pertains to pressure ulcers.	C 789	C 789 Refer to F 314	
C 790	02.200,03,b,vi Protection from Injury/Accidents vi. Protection from accident or injury; This Rule is not met as evidenced by: Please see F 323 as it pertains to fall prevention.	C 790	C 790 Refer to F 323	
C 798	02.200,04,a MEDICATION ADMINISTRATION Written Orders 04. Medication Administration. Medications shall be provided to patients/residents by licensed nursing staff in accordance with established written procedures which shall include at least the following: a. Administered in accordance with physician's dentist's or nurse practitioner's written orders; This Rule is not met as evidenced by: Please refer to F 333 as it relates to not following physician's written orders.	C 798	C 798 Refer to F 333	
C 823	02.201,01,d Review Narcotic and Dangerous Med Logs d. Reviewing the narcotic and	C 823	C 828 Refer to F 431	

Bureau of Facility Standards

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C 823	<p>Continued From page 2</p> <p>dangerous drug records at least every thirty (30) days and certifying to the administrator that this inventory is correct.</p> <p>This Rule is not met as evidenced by: Please refer to F431 as it relates to reconciliation of meds.</p>	C 823		



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

October 28, 2013

Mark Teckmeyer, Administrator
Rexburg Care & Rehabilitation Center
660 South Second Street West
Rexburg, ID 83440-2300

Provider #: 135105

RE: Complaint Findings for Rexburg Care & Rehabilitation Center

Dear Mr. Teckmeyer:

On **October 2, 2013**, a Complaint Investigation survey was conducted at Rexburg Care & Rehabilitation Center. Amy Jensen, R.N. and Nina Sanderson, L.S.W. conducted the complaint investigation.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00006024

ALLEGATION #1:

The complainant stated the kitchen was not clean and sanitary. Specifically, the dishwashing sink was not clean; there was opened, undated and unlabeled food in the refrigerator; and the inside of the microwave was not clean.

FINDINGS:

The facility kitchen was inspected on September 23, 2013, September 30, 2013, October 1, 2013 and October 2, 2013. On all occasions, the dishwashing sink was clean and in good repair. Food was stored properly in the refrigerator and was properly covered, labeled and dated as required. The microwave was clean on all inspection opportunities.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

Mark Teckmeyer, Administrator
October 28, 2013
Page 2 of

ALLEGATION #2:

The complainant stated the residents' bathrooms and public restrooms were not clean.

FINDINGS:

The residents' rooms, bathrooms and the public restrooms were observed on September 23, 2013, September 24, 2013, and again on September 30, 2013 through October 2, 2013. They were consistently noted to be clean and odor-free. Individual residents and the resident group were asked about the cleanliness of their rooms, bathrooms, and the facility at large. The residents consistently stated their living space and the facility as a whole was clean, odor-free and pest-free.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The complainant stated the residents were given canned fruit instead of fresh fruit for snacks.

FINDINGS:

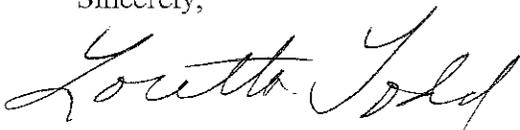
Facility's menus were reviewed, individual residents interviewed and a resident group interview conducted. The Dietary Manager was interviewed. The residents stated they were offered fresh fruit. The Dietary Manager stated the facility offered seasonal fruits, which were on a rotating schedule depending on the season. More fresh fruits were available in the spring and summer months than the fall and winter. However, during the fall and winter, fresh apples, bananas, grapes and oranges were always available.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

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

Sincerely,



LORETTA TODD, R.N., Supervisor
Long Term Care

LT/dmj