



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

December 15, 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 **December 11, 2014**, we conducted an on-site follow-up revisit to verify that your facility had achieved and maintained compliance. We had presumed, based on your allegation of compliance, that your facility was in substantial compliance as of **November 3, 2014**. However, based on our on-site follow-up revisit conducted **December 11, 2014**, we found that your facility is not in substantial compliance with the following participation requirements:

F328 -- S/S: D -- 42 CFR §483.25(k) -- Treatment/Care for Special Needs
F425 -- S/S: D -- 42 CFR §483.60(a),(b) -- Pharmaceutical Services - Accurate Procedures, RPH
F514 -- S/S: D -- 42 CFR §483.75(l)(1) -- Resident Records - Complete/Accurate/Accessible

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 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 copy of the Post-Certification Revisit Report, Form CMS-2567B, listing deficiencies that have been corrected is enclosed.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **December 29, 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*.

As noted in the letters of **August 6, 2014**, following the **Recertification, Complaint Investigation and State Licensure** survey of **July 25, 2014**, and in the letters following the **Complaint Investigations** of **August 28, 2014**, and **September 26, 2014**, we have already made the recommendations to the Centers for Medicare and Medicaid Services (CMS) for Denial of Payment for New Admissions (DPNA) and termination of the provider agreement on **January 25, 2015**, if substantial compliance is not achieved by that time. CMS' remedies included:

A 'per instance' civil money penalty of \$9250.00, and

A DPNA effective as of **October 25, 2015**.

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

Kelly Spiers, Administrator
December 15, 2014
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separate formal notification of that determination.

If you believe the deficiencies have been corrected, you may contact Lorene Kayser, L.S.W., Q.I.D.P. or David Scott, R.N., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option #2; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance.

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 **December 29, 2014**. If your request for informal dispute resolution is received after **December 29, 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 on-site follow-up revisit. If you have any questions, comments or concerns, please contact Lorene Kayser, L.S.W., Q.I.D.P. or David Scott, R.N., Supervisors, Long Term Care at (208) 334-6626.

Sincerely,



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

LKK/dmj
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135138	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 12/11/2014
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
{F 000}	INITIAL COMMENTS The following deficiencies were cited during the follow-up to the annual recertification survey of your facility. The surveyors conducting the survey were: Arnold Rosling RN, BSN, QMRP Linda Hukill-Neil, RN. The survey team entered the facility on December 8 and exited on December 11, 2014. Survey Definitions: DNS = Director of Nursing Services LN = Licensed Nurse MAR = Medication Administration Record MDS = Minimum Data Set assessment NH = Nursing Home S&C = Survey and Certification TAR = Treatment Administration Record	{F 000}	<u>DISCLAIMER CLAUSE</u> 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. <i>F328</i> • <i>How corrective action accomplished for the identified residents?</i> Resident#18 has had their respiratory care plan updated on 12/08/14. And oxygen saturations monitored as of 12/16/14. • <i>How you will identify other residents with the potential of being affected by the same practice?</i> Residents with respiratory needs have had their care plans reviewed by the interdisciplinary team on or before 12/16/14 to validate they are updated and accurate, including the documentation of oxygen saturations levels.	
{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:	{F 328}		

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DEC 19 2014

FACILITY STANDARDS

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

TITLE

(X6) DATE

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 328}	<p>Continued From page 1</p> <p>Based on observation, record review, and resident and staff interview, it was determined the facility failed to ensure oxygen therapy was being assessed and monitored. This was true for 1 of 9 (#18) sample residents. This failure created the potential for respiratory problems if the resident's respiratory needs were not met. Findings included:</p> <p>Perry & Potter's, Clinical Nursing Skills & Techniques, 7th Edition, 2010, states on p. 629, "Treat oxygen therapy as a medication...As with any drug, continuously monitor the dosage or concentration of oxygen. Routinely check the health care provider's orders to verify that the patient is receiving the prescribed oxygen concentration. The six rights of medication administration also pertain to oxygen administration [including right patient, right medication, right dose, right mode, and right time]."</p> <p>Resident #18 was readmitted to the facility on 11/14/14, after an Interthecal Dilaudid pain pump placement. The resident had multiple diagnoses including lumbar compression fractures, chronic pain, atrial fibrillation, and hypertension.</p> <p>Resident #18's MDS assessment, dated 11/21/14 coded, in part, oxygen (O2) therapy.</p> <p>The resident did not have a respiratory care plan initiated on his original admit date of 11/1/14, when he was on oxygen and or upon readmit on 11/14/14.</p> <p>The resident's Admission Orders dated 11/13/14 documented, "Oxygen 2 lpm [liters per minute] ...to maintain sats [saturation] > [greater than]"</p>	{F 328}	<ul style="list-style-type: none"> <i>Address what measures will be put in place to ensure deficient practice will not recur.</i> Nursing staff will be re-educated by the Director of Nursing and or designee on updating respiratory care plans to match the physician orders, and the care directive. Education also included the documentation of oxygen saturations on the medication record. <i>How will the plan be monitored to ensure the solutions are sustained?</i> The Director of Nursing and or designee will audit care plans to validate that respiratory care plans match physician orders, care directives, oxygen saturations on the medication record. These audits will be completed: 3 days a week X4 weeks, then 2 days a week X4 weeks, and then 1 day a week for 1 month. 	

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

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{F 328}	<p>Continued From page 2 90%."</p> <p>The resident's December 2014 Physician's Orders recapitulation documented, "Oxygen (O2) at 2 L/min [liters per minute] per nasal cannula Notes: TO KEEP SATS ABOVE 90% WHEN CHECKED... as needed starting 11/14/2014."</p> <p>Resident #18's November 2014 MAR documented, "O2 @ [at] 2 L to maintain sats > 90%". Nurses initials on day and night shifts starting on 11/18/14 (4 days after readmission) through 11/30/14, documented oxygen saturation levels for 9 of 26 shifts and no liter flow rate for any of the shifts.</p> <p>Resident #18's December 2014 TAR documented, "Oxygen (O2) at 2 L/min per nasal cannula As Needed Starting 11/14/2014...Notes: TO KEEP SATS ABOVE 90% WHEN CHECKED. However, there was no documentation of O2 lpm, saturation level or if oxygen was administered to the resident from 12/1/14 through 12/9/14.</p> <p>On 12/8/14 at 2:50 PM and 12/10/14 at 9:40 AM, resident was observed in his room, resting on his bed with oxygen set at 2 L/min via nasal cannula. The resident said he had fractures in his low back and he was in a lot of pain and with the oxygen help, he did not have to take deep breaths.</p> <p>On 12/10/14 at 10:05 AM, the DNS was informed of the oxygen monitoring and care concerns after surveyor's observations and review of Resident #18's medical record. The DNS acknowledged there should have been a respiratory care plan and monitoring was not reflected as being done according to the TAR.</p>	{F 328}	<p>Findings will be brought to CQI monthly for further review and educational opportunities.</p> <ul style="list-style-type: none"> The DNS is responsible for compliance <p>Compliance date is 12/16/14</p>	

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{F 328}	<p>Continued From page 3</p> <p>On 12/10/14 at 10:55 AM, the Regional Nurse Consultant said the facility does not have any Respiratory/Oxygen Policy and Procedures.</p> <p>On 12/10/14 at 4:45 PM, the Administrator and the DNS were informed of the issue. At the exit conference on 12/11/14, the facility provided a Quality Assurance/Performance Improvement Plan addressing an action plan for the oxygen monitoring and had already initiated a Respiratory Care Plan for Resident #18.</p> <p>483.60(a),(b) PHARMACEUTICAL SVC-- ACCURATE PROCEDURES, RPH.</p> <p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	{F 328}	<p><i>F425</i></p> <ul style="list-style-type: none"> <i>How corrective action accomplished for the identified residents?</i> LN #1 was re-educated by the Staff Development Coordinator on 12/11/14 to have two signatures of licensed nurses when destroying used fentanyl patches and to document the destruction on the Medication Record. <i>How you will identify other residents with the potential of being affected by the same practice?</i> Medication records have been reviewed by the IDT team on or before 12/16/14 to validate two signatures of licensed nurse have been obtained when destroying the medication and documenting the destruction on the Medication Record. 	

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F 425	<p>Continued From page 4</p> <p>Based on observation, record review, staff interview, and policy review, it was determined the facility failed to ensure the disposal of used fentanyl patches (a controlled medication) was witnessed by 2 licensed staff and documented. This was true for 1 sampled resident (#8) during medication pass observations. The failed practice created the potential of harm from the diversion of the resident's used fentanyl patch. Findings included:</p> <p>Informational Letter, Reference: S&C: 13-02 NH, states, in part, "Fentanyl transdermal patches are a controlled substance commonly used in nursing homes for pain medication. These patches present a unique situation given the multiple boxed warnings, the potential for abuse, misuse and diversion, and the substantial amount of fentanyl remaining in the patch after use. 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 the medications. One benefit of the patch is the continuous delivery of fentanyl over 72 hours. This slow-release of fentanyl from the transdermal reservoir allows for more consistent pain control in patients with chronic pain. This unique delivery system, however, is not impervious to diversion, even after the fentanyl patch has been used, removed and/or disposed. One study determined that even after three days of use, 28 to 84.4% of the original fentanyl dose was still present in the patch. The study noted that the dose remaining in the patch was within the limits of a lethal fentanyl dose.</p> <p>The remaining fentanyl in a used patch is a potential vehicle of abuse and accidental</p>	F 425	<ul style="list-style-type: none"> • <i>Address what measures will be put in place to ensure deficient practice will not recur.</i> Nursing staff will be re-educated by the Director of Nursing and or designee on having two signatures of licensed nurses when destroying fentanyl patch medications when they document the destruction on the Medication Record. • <i>How will the plan be monitored to ensure the solutions are sustained?</i> The Director of Nursing and or designee will audit medication records to validate that there is two signatures from licensed nurses present when destroying fentanyl patches' destruction on the Medication Record. The audits will be completed 3 days a week X4 weeks then 2 days a week X4 weeks, and then 1 day a week for 1 month. 	

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F 425	<p>Continued From page 5</p> <p>overdose and warrants implementation of adequate disposal policies. Fentanyl products contain several boxed warnings related to potential abuse, misuse, and diversion, and specifically, the contraindication of fentanyl transdermal patch use in individuals who are not opioid tolerant.</p> <p>Staff should dispose of fentanyl patches in the same manner as wasting of any other controlled substances, particularly because the active ingredient is still accessible. Wasting must involve a secure and safe method, so diversion and/or accidental exposure are minimized. ..."</p> <p>The facility's Policy and Procedures for Disposal/Destruction of Expired or Discontinued Medications documented: "...Facility should destroy controlled substances in the presence of a registered nurse and a licensed professional in accordance with Facility policy or Applicable Law. Destruction of controlled medications should be documented on the controlled medication count sheet and signed by the registered nurse and witnessing licensed professional..."</p> <p>On 12/9/14 at 1:55 PM, LN #1 was observed as she prepared to place a Fentanyl patch on Resident #8. The LN removed the resident's used Fentanyl patch from the left chest area, folded it up, and placed it in the foil wrap, from which she had removed the new Fentanyl patch. The LN placed the new Fentanyl patch on the right chest area and exited the resident's room. She then disposed of the used Fentanyl patch in the sharps container located on the medication cart. LN #1 stated, "I dispose of mine this way. I know others may flush it down the toilet. This is all I have to do."</p> <p>A second licensed staff did not witness the</p>	F 425	<p>Findings will be brought to CQI monthly for further review and educational opportunities.</p> <ul style="list-style-type: none"> • <i>The DNS is responsible for compliance</i> <p><i>Compliance date is 12/16/14</i></p>	

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F 425	Continued From page 6 disposal and there was no documentation of the disposal of the used fentanyl patch. On 12/9/14 at 4:45 PM, the DNS and Regional Nurse Consultant were informed of the observation where only one LN disposed of a used Fentanyl patch and no additional documentation was made for the disposal. The DNS and Regional Nurse Consultant were asked if they were familiar with the informational letter regarding the disposal of used Fentanyl patches. They both said they were not sure of the information on this letter, but the facility did have Policies and Procedures for Controlled Medications. The DNS said she was not aware of any procedure in place to deal with used Fentanyl patches. On 12/10/14 at 4:45 PM, the Administrator and DNS were informed of the Fentanyl patch issue. At the exit conference on 12/11/14 the facility provided a Quality Assurance/Performance Improvement Plan addressing their action plan for used Fentanyl patch disposition.	F 425	<i>F514</i> <ul style="list-style-type: none"> How corrective action accomplished for the identified residents? Resident #18 has had his physician order for advanced directives updated to match the POST by the Director of Nursing on 12/10/14. How you will identify other residents with the potential of being affected by the same practice? Resident's physician orders for advanced directives have been reviewed by the IDT team on or before 12/16/14 to validate that they are accurate and match the POST. 	
{F 514} SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE 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. 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	{F 514}		

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{F 514}	<p>Continued From page 7 preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility failed to maintain accurate, complete, and organized clinical records. This was true for 1 of 8 (#18) sampled residents. This created the potential for a medical decision error in regards to the resident's code status. Findings included:</p> <p>Resident #18 was readmitted to the facility on 11/14/14 with multiple diagnoses including lumbar compression fractures, lack of coordination, and chronic pain.</p> <p>The resident's December 2014 recapitulation Physician's Orders documented, "Do Not Resuscitate", with an order date of 11/14/14.</p> <p>The resident's Idaho Physician Orders for Scope of Treatment (POST) signed and dated by the resident's daughter on 11/3/14, documented, "Resuscitate (Full Code)."</p> <p>On 12/9/14 at 3:45 PM, the DNS was interviewed regarding the status issue. When shown the discrepancy in the medical records, the DNS stated staff would follow the code status on the POST. She said the Physician's order was inaccurate and would be corrected.</p> <p>On 12/10/14 at 4:45 PM, the Administrator and the DON were informed of the issue. The facility did provide additional documentation after awareness of the discrepancies. The facility</p>	{F 514}	<ul style="list-style-type: none"> • <i>Address what measures will be put in place to ensure deficient practice will not recur.</i> Nursing staff will be re-educated by the Director of Nursing and or designee on validating residents have accurate physician orders for advanced directives that match the POST. • <i>How will the plan be monitored to ensure the solutions are sustained?</i> The Director of Nursing and or designee will audit resident code status to validate the POST matches the physician orders for advanced directives. This audit will be completed 3 days a week X4 weeks, then 2 days a week X4 weeks, and then 1 day a week for 1 month. 	

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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)	(X6) COMPLETION DATE	
{F 514}	Continued From page 8 provided their Policy on Idaho POST and another POST signed and dated by the resident's daughter on 12/10/14 with "Resuscitate (Full Code)".	{F 514}	Findings will be brought to CQI monthly for further review and educational opportunities. <ul style="list-style-type: none"> The DNS is responsible for compliance. <p>Compliance date is 12/16/14</p>		

Bureau of Facility Standards

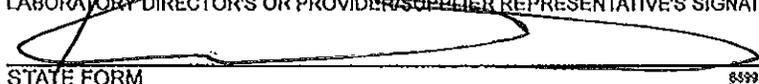
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001775	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 12/11/2014
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NAME OF PROVIDER OR SUPPLIER TETON POST ACUTE CARE & REHABILITATIO	STREET ADDRESS, CITY, STATE, ZIP CODE 3111 CHANNING WAY IDAHO FALLS, ID 83404
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(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) COMPLETE DATE
{C 000}	16.03.02 INITIAL COMMENTS The following deficiencies were cited during the follow-up to the annual licensure survey of your facility. The surveyors conducting the survey were: Arnold Rosling RN, BSN, QMRP Linda Hukill-Neil, RN. The survey team entered the facility on December 8, 2014 and exited on December 11, 2014.	{C 000}		
C 824	02.201,01,e Formulation of Pharmacy Policies/Procedures e. Participating in the formulation of pharmacy service policies and procedures in conjunction with the administrator, director of nursing service, and the physicians(s) responsible for the medical direction of the facility. This Rule is not met as evidenced by: Refer to F425 in regards to the disposition of controlled medications including Fentanyl patches.	C 824	C824 Refer to the plan of correction for F425 on the 2567.	
{C 881}	02.203,02 Individual Medical Record 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:	{C 881}	C881 Refer to the plan of correction on the 2567 for F514.	

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DEC 19 2014
FACILITY STANDARDS

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



TITLE

Administrator

(X6) DATE

12-17-14

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001775	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 12/11/2014
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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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(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) COMPLETE DATE
{C 881}	Continued From page 1 This Rule is not met as evidenced by: Refer to F514 as it relates to the POST and Physicians Orders.	{C 881}		