



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 Eder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

January 16, 2015

Monte A. Jones, Administrator
Rexburg Care & Rehabilitation Center
660 South Second Street West
Rexburg, ID 83440-2300

FILE COPY

Provider #: 135105

Dear Mr. Jones:

On **December 18, 2014**, a Recertification and State Licensure survey was conducted at Rexburg Care & Rehabilitation Center by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be an isolated deficiency that constitutes actual harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies 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.) **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 the 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 **January 29, 2015**. Failure to submit an acceptable PoC by **January 29, 2015**, may result in the imposition of civil monetary penalties by **February 18, 2015**.

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*.

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

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

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **June 18, 2015**, if substantial compliance is not achieved by that time.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare &

Monte Jones, Administrator
January 16, 2015
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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 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, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, Fax #: (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. 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 **January 29, 2015**. If your request for informal dispute resolution is received after **January 29, 2015**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, comments or concerns, please contact Lorene Kayser, L.S.W., Q.I.D.P. or David Scott, R.N., Supervisors, Long Term Care at (208) 334-6626, Option #2.

Sincerely,



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

LKK/dmj
Enclosures

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

PRINTED: 01/16/2015
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 12/18/2014
NAME OF PROVIDER OR SUPPLIER REXBURG CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 660 SOUTH SECOND STREET 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	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the annual federal recertification and complaint survey of your facility. The survey team entered the facility on December 14, and exited on December 18, 2014.</p> <p>The surveyors conducting the survey were: Sherri Case, BSW, LSW, QIDP, Team Coordinator Linda Kelly, RN Kirsti Stephenson, RN</p> <p>Survey Definitions: ADL = Activities of Daily Living BIMS = Brief Interview for Mental Status CNA = Certified Nurse Aide CVA = Cerebral Vascular Accident DNS/DON = Director of Nursing Services LN = Licensed Nurse MAR = Medication Administration Record MDS = Minimum Data Set assessment MG = Milligram ML = Milliliter PRN = As Needed TAR = Treatment Administration Record WC = Wheelchair</p>	F 000	<p>"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 statement, 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."</p>	
F 176 SS=D	<p>483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE</p> <p>An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 176	<p>F176</p> <p>1) On or before February 20th 2015 resident #5 and resident #13 were assessed by the director of nursing or designee for any adverse reaction noted related to self-administration of medications with no adverse effects noted. At that time Director of Nursing or designee assessed for</p>	

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

TITLE

(X6) DATE



Administrator

2-12-15

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 176	<p>Continued From page 1</p> <p>Based on observation, staff interview, and record review, it was determined the facility failed to ensure residents who wished to self-administer medications were safe to do so. This was true for 1 of 6 residents (#5) during medication pass observations and one random resident (#13) observed to be alone during a nebulizer treatment. The failure created the potential for medication errors if the residents were not competent to self administer their medications. Findings included:</p> <p>1. On 12/16/14 at 10:20 AM, Resident #13 was observed alone in her room and seated on her bed taking a nebulizer treatment using a mouthpiece.</p> <p>On 12/16/14 at 10:21 AM, LN #4 asked what the resident's nebulizer treatment was. The LN said it was Perforomist (formoterol fumarate, a bronchodilator). When asked if the resident had been assessed to determine if she was safe to self-administer the nebulized medication, LN #4 stated, "Yes. She's been here a long time." The LN was asked to provide the resident's medication self-administration assessment for the nebulized medication. The LN looked through the resident's clinical record, indicated she did not find such an assessment, and stated, "It might be in her thinned record. I'll look."</p> <p>On 12/16/14 at 10:40 a.m., LN #4 said she did not find a medication self-administration assessment for the resident. She added, "But I will be filling one out today."</p> <p>2. Resident #5 was re-admitted to the facility on 11/12/14 with multiple diagnoses including aftercare healing traumatic lower leg fracture,</p>	F 176	<p>ability to self-administer medications with no new orders received.</p> <p>2) Resident's 90 day nursing assessment were reviewed for wishes to self-administer medication by Director of Nursing or designee on or before February 20th 2015. No resident is currently self-administering medications.</p> <p>3) Licensed staff were re-educated by the Director of Nursing or designee on or before February 20th 2015 to complete self-administration evaluation if resident wishes to self-administer medications. New admission and quarterly records will be reviewed in the morning clinical meeting to verify evaluation for self-administration of medication is completed.</p> <p>4) Beginning the week of February 23rd, 2015, Director of Nursing or designee will review 3 admissions per week for 4 weeks, and then monthly for 2 months to ensure self-administration of medication is completed per policy. Audit results will be reported to the Performance Improvement Committee for a minimum of 3 months or until compliance sustained.</p>	

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F 176	<p>Continued From page 2</p> <p>acute renal failure, atrial fibrillation and hypertension.</p> <p>The resident's most recent Significant Change MDS, dated 11/19/14, documented the following: * BIMS 13, indicating intact cognition * No swallowing disorder</p> <p>During a medication administration observation on 12/15/14 at 3:15 p.m., LN#1 poured omeprazole, carvedilol, and colace for Resident #5 and took them to the resident in her room. The resident took the omeprazole then asked, "Where are the rest of my pills?" LN#1 asked the resident if she needed something for pain and the resident said yes. The LN told the resident she would get her some Tylenol then the LN left the resident's room. While LN#1 was out of the room, the resident took the carvedilol and colace. Within moments, LN #1 returned and gave the resident medication which she said was Tylenol.</p> <p>At 4:20 p.m., LN #1 was asked how she knew the resident had taken the carvedilol and colace. The LN stated, "I don't. I left to go get her pain med. I'm sorry. I should have taken the med cup with me."</p> <p>On 12/16/14 the Unit Manager (UM) was asked if Resident #5 had been assessed to self-administer medications. The UM looked through the resident's clinical record and stated, "I want to say no." When informed of the aforementioned observation, the UM stated, "The nurse probably should have taken the pills with her."</p> <p>The facility did not provide documentation to show the resident had been assessed to safely</p>	F 176	<p>5) The Director of Nursing is responsible for monitoring and compliance.</p> <p>Compliance Date: 02/20/2015</p>	

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F 176	Continued From page 3 self-administer medications.	F 176		
F 280 SS=D	<p>On 12/17/14 at 6:10 p.m., the Administrator, DON, and Nurse Consultant were informed of the issue. The facility did not provide any other information regarding the issue.</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and resident and staff interview, it was determined the facility failed to ensure care plans were updated for 2 of 7 (#s 5 and 6) residents reviewed for care plans. Failure to ensure care plans were revised and accurate</p>	F 280	<p>F280</p> <p>1) Residents # 5 and # 6 self-care deficit care plan was updated on or before February 20th 2015 to reflect current assistance needed with ambulation and oral cares by the Director of Nursing or designee.</p> <p>2) Resident self-care deficit care plans and resident Kardex were reviewed by the interdisciplinary team on or before February 20th 2015 to ensure care plans and Kardex reflected resident's current functional status. Care plans and Kardex were updated as indicated by the Director of Nursing or designee on or before February 20th 2015.</p> <p>3) Center staff were re-educated by the Director of Nursing or designee on or before February 20th 2015 regarding updating care plans and Kardex to reflect resident's current status.</p> <p>Care plans and Kardex will be reviewed by the interdisciplinary</p>	

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F 280	<p>Continued From page 4</p> <p>created the potential for residents to not get needed care and services. Findings include:</p> <p>1. Resident #5 was admitted to the facility on 10/28/11 and readmitted on 11/12/14 with diagnoses that included aftercare for a lower leg fracture, anxiety state and history of falls.</p> <p>The 11/19/14 Significant Change MDS documented the resident was cognitively intact and needed assistance of one for ADLs.</p> <p>a. The resident's 10/24/14 Care Plan with a goal to improve ADL function included an intervention for, "Oral care BID [twice a day] and PRN [as needed]." The care plan did not include any further instructions such as assist the resident to the sink, provide the resident with a toothbrush etc.</p> <p>On 12/15/14 at 11:45 AM the resident was asked if she was assisted to brush her teeth. The resident stated she did not want to "bother" anyone and kept her toothpaste in the drawer by her chair and would use her finger with the toothpaste to brush her teeth.</p> <p>On 12/17/14 at 1:30 AM the DON stated the Care Plan needed to be revised to include specific interventions to provide the resident with the assistance or tools she needed to brush her teeth.</p> <p>b. Resident #5's medical record included a 12/11/14 verbal physician's order to "Remove right boot daily for ROM [range of motion] for 20 min[utes].....Otherwise boot on day and night."</p> <p>The resident's 11/13/14 Care Plan for a surgical</p>	F 280	<p>team during the center morning clinical meeting during a review of including but not limited to the 24 hour report and physician orders.</p> <p>4) Beginning the week of February 23rd, 2015, Director of Nursing or designee will review 3 resident care plans per week for 4 weeks, then monthly for 2 months to ensure care plans are reflective of resident's current status. Audit results will be reported to the Performance Improvement Committee for a minimum of 3 months or until compliance sustained.</p> <p>5) The Director of Nursing is responsible for monitoring and compliance.</p> <p>Compliance Date: 02/20/2015</p>	

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F 280	<p>Continued From page 5</p> <p>inclusion included in the interventions, dated 11/25/14, "Resident has walking boot to right lower extremity."</p> <p>On 12/17/14 at 1:30 a.m. the DON stated the Care Plan needed to be clarified to state the boot was to be worn at all times and removed daily for ROM.</p> <p>2. Resident #6 was admitted to the facility on 6/19/13 with diagnoses that included muscular wasting, impulse control disorder and bipolar disorder.</p> <p>During observations on 12/14/14 the resident was assisted by CNA #6 walk to the dining room with the use of a gait belt. On 12/16/14 at 12:30 PM CNA#7 walked the resident to the dining room using a gait belt.</p> <p>The resident's 8/16/11 Care Plan with a goal of "no significant injury related to a fall," included an intervention, dated 6/30/14, for the resident to ambulate to and from meals with [staff assistance using] a gait belt." However, the resident's 8/16/11 Care Plan to "maintain ADL status" included an intervention, dated 6/30/14, "...may ambulate independently. Resident can use cane or walker or no device when ambulating."</p> <p>On 12/17/14 at 1:30 PM the DON stated the ADL Care Plan was incorrect and needed to be revised to include the resident's need for staff assistance.</p> <p>On 12/18/14 at 10:15 PM the Administrator and the DON were informed of the above concerns. The facility provided no further information.</p>	F 280		

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F 281 F 281 SS=D	Continued From page 6 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, observation, staff interview, and policy review, it was determined the facility failed to ensure alcohol was allowed to dry completely and the first drop of blood was wiped away before the blood glucose (BG) level for 1 of 12 sample residents (#9) was checked. The failure created the potential for inaccurate BG results which could lead to adverse reactions if unnecessary insulin was given. Findings include: Regarding BG testing, Clinical Nursing Skills, 7th edition, 2010, by Perry and Potter, state, "...11 Clean site with antiseptic swab, and allow it to dry completely...14 Wipe away first droplet of blood with cotton ball...First drop of blood may contain more serous fluid than blood cells...15 Lightly squeeze puncture site (without touching) until large droplet of blood has formed...16 Obtain test results..." Resident #9 was readmitted to the facility on 11/18/14 with multiple diagnoses including diabetes mellitus. On 12/15/14 at 4:30 PM, LN#1 was observed as she monitored Resident #9's BG. The LN wiped the resident's finger with an alcohol pad then quickly punctured the resident's finger with a	F 281 F 281	F281 1) On or before February 20th 2015, resident # 9 was assessed by Director of Nursing or designee with no adverse findings related to not wiping first drop of blood noted at the time of assessment. 2) Other residents having blood glucose checked were reviewed on or before February 20th 2015 by Director of Nursing or designee to ensure first blood sample is wiped and alcohol dried. 3) System Changes - Licensed nursing were educated regarding new procedure by the Director of Nursing or designee on or before February 20th 2015 regarding need to wipe first sample of blood prior to blood glucose testing. Current licensed nurse competencies for blood glucose testing was completed by Director of Nursing or designee on or before February 20th 2015 to ensure first blood sample wiped and alcohol allowed to dry. On-going competencies to be completed quarterly and on hire. 4) Beginning the week of February 23 rd , 2015, Director of Nursing or designee will review 3 blood glucose	

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F 281	<p>Continued From page 7</p> <p>lancet and used the first drop of blood to check the BG. The BG was 185. The LN administered Humalog insulin to the resident per the sliding scale orders.</p> <p>On 12/15/14 at 6:20 p.m., the DON was asked to provide the facility's policy and procedure (P&P) regarding BG monitoring.</p> <p>On 12/16/14 at 4:00 PM, LN#3 was observed as she checked Resident #9's BG. LN#3 wiped the resident's finger with an alcohol pad, waited several seconds, punctured the resident's finger with a lancet, wiped away the first drop of blood with a cotton ball, then used the second drop of blood to check the BG. The BG was 90. Sliding scale insulin was not needed.</p> <p>In the afternoon on 12/16/14, the DON provided a "Fingerstick Glucose Measurement" document. She indicated it was the facility's P&P for BG monitoring. It included the following documentation, "...9. Select puncture site...10. Wipe site with alcohol pad and allow to dry thoroughly. 11. Position the lancet...pierce the skin quickly. 12. Touch a drop of blood onto the reagent strip...14. Note blood glucose level on meter..." The DON was asked to provide manufacturer's information for the glucometers used in the facility.</p> <p>In the morning on 12/17/14, the DON provided a document titled "Glucose Meter." The document did not include any manufacturers' information and it did not provide the process or steps of how to monitor a BG.</p> <p>On 12/17/14 at 6:10 PM, the Administrator, DON, and Nurse Consultant (NC) were informed of the</p>	F 281	<p>testing per week for 4 weeks, then monthly for 2 months to ensure first blood sample wiped prior to testing and alcohol allowed to dry. Audit results will be reported to the Performance Improvement Committee for a minimum of 3 months or until compliance sustained.</p> <p>5) The Director of Nursing is responsible for monitoring and compliance.</p> <p>Compliance Date: 02/20/2015</p>	

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NAME OF PROVIDER OR SUPPLIER REXBURG CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 660 SOUTH SECOND STREET WEST REXBURG, ID 83440	
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F 281	Continued From page 8 two different observations. When asked which clinical nursing skills reference the facility used regarding BG monitoring, the NC indicated the facility used information from their corporate office and did not use any other reference material. On 12/22/14 at 4:43 PM, the Bureau of Facility Standards received a 5 page facsimile (fax) from the facility. The fax included an article titled "Procedure Guidelines 25-1 Blood Glucose Monitoring Technique" which documented, "...Prick the patient's finger...obtaining a large, hanging drop of blood..." However, the article did not include any publication information and the facility did not provide the source of the article. The faxed information did not resolve the issue.	F 281		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to adequately monitor a resident's skin in order to identify the development of pressure ulcers for 1 of 3 (#3) residents reviewed for pressure ulcers.	F 314	<u>F314</u> 1) Resident #3 was assessed by the Director of Nursing or designee for skin breakdown with MD and family notification, new orders received and interventions implemented on or before February 20 th 2015. 2) Current residents had head to toe skin assessments completed by licensed nurse staff on or before February 20 th 2015 to ensure no unidentified areas of breakdown were noted. No previously unidentified findings noted at time of assessment.	

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F 314	<p>Continued From page 9</p> <p>During the survey, a staff member and surveyors found a previously undetected suspected deep tissue injury (SDTI) on the Resident #3's left (L) heel. Findings include:</p> <p>Resident #3 was admitted to the facility on 6/4/12 with multiple diagnoses including cerebrovascular accident (CVA) and myelodysplastic syndrome (a bone marrow disorder in which the bone marrow does not produce enough healthy blood cells, often referred to as a "bone marrow failure disorder").</p> <p>The resident's 10/7/14 quarterly MDS documented: intact cognition with a BIMS score of 14; total assistance needed with bed mobility, transfers, locomotion on and off the unit, dressing, toilet use, personal hygiene, and bathing; at risk for developing pressure ulcers; no unhealed or healed pressure ulcers and no venous or arterial ulcers; no other ulcers, wounds or skin problems; and chair and bed pressure reducing devices.</p> <p>Braden Skin Assessments dated 10/5/14 and 12/15/14 documented the resident was at moderate risk for developing pressure ulcers.</p> <p>Care plan focus areas included, "[A]t risk for skin breakdown r/t (related to)...impaired mobility." Interventions and their respective initiation dates included, "float heels in bed as resident allows" 4/24/14; "Report new open areas to LN" 6/4/12; "Follow center protocol/regime for treating breaks in skin integrity," "Pressure reducing/relieving devices as ordered," and "Weekly skin assessment per protocol," all on 6/4/12; "Podus boots as ordered" 12/2/14 and "Cushion to pedals of w/c [wheelchair]" 12/12/14.</p>	F 314	<p>3) System Changes - Nursing staff were re-educated by Director or Nursing or designee on or before February 20th 2015 regarding weekly skin assessments which include inspection and palpation and documenting any findings as well as practitioner and family notifications.</p> <p>Mirrors placed at nurses stations by the Director of Nursing or designee on or before February 20th 2015 to assist with inspection of heels during licensed nurse weekly skin assessment.</p> <p>Implementation of checking skin integrity under pressure reducing boots every shift.</p> <p>Licensed nurse skin assessment competencies were completed by nurse management team on or before February 20th 2015.</p> <p>Certified Nursing Aides were re-educated on daily observation of skin and reporting abnormal findings on or before February 20th 2015 by the Director of Nursing or designee.</p> <p>4) Beginning the week of February 23rd, 2015, Director of Nursing or designee will complete 3 follow behind skin assessments and observe 3 resident cares a week for</p>		

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F 314	<p>Continued From page 10</p> <p>The resident's Order Summary Report dated 12/2/14 included the following physician active orders and their start dates, "Skin Check weekly Code: (1) No skin injury/wound (2) New skin injury/wound-see new Skin Integrity Report (3) Previously noted skin injury/wound-see updated Skin Integrity Report every night shift every Wed[nesday]" 9/25/14 and "boots to be worn at all times, every shift" 12/2/14.</p> <p>A subsequent 12/12/14 Verbal order documented, "Podus boots to be worn while in bed every day and night shift to...protect heels and feet."</p> <p>On 12/15/14 at 9:30 a.m., the resident was observed awake in bed with blue Podus boots on both feet. CNA #5 was present and she talked to the resident and washed his face and eyes. During the care, the resident grunted and pointed toward his left leg/foot several times. The CNA attempted to communicate with the resident for several minutes without success. The CNA told the resident she would get someone who could understand him then she left the room.</p> <p>On 12/15/14 at 9:45 a.m., the Unit Manager (UM) and CNA #5 returned to the resident's room. The UM determined the resident wanted his hair to be washed and that his left foot was hurting. At the surveyor's request, the UM removed the left Podus boot. A pinpoint size scab was noted next to the toenail at the lateral aspect of the little toe. The LN stated, "After finding this, I checked his shoes and the left shoe had a rough spot right where his toe would be. We stopped having him wear his shoes and added the Podus boots." The UM raised the resident's left foot and a large purplish black area was noted at the bottom and</p>	F 314	<p>4 weeks, then monthly for 2 months to ensure findings on weekly assessments are accurate. Audit results will be reported to the Performance Improvement Committee for a minimum of 3 months or until compliance sustained.</p> <p>5) The Director of Nursing is responsible for monitoring and compliance.</p> <p>Compliance Date: 02/20/2015</p>	

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F 314	<p>Continued From page 11</p> <p>back of the heel. The area was smooth and intact with dry edges all around. It was circular and approximately 3 centimeter (cm) by 2.5 cm. There was no evidence of fluid displacement and no signs or symptoms of discomfort when the UM palpated the area. The UM indicated the area was a new SDTI. At the surveyor's request, the UM removed the right Podus boot and as she did she stated, "This boot is on upside down." No skin issues were observed on the right foot. The UM correctly reapplied both Podus boots then she left the room.</p> <p>On 12/15/14 at 1:50 p.m., the UM, Nurse Consultant (NC), and LN #3, were observed in the resident's room looking at his left foot. The NC stated, "We are going to switch to a heel lift cushion."</p> <p>On 12/15/14 at 4:55 p.m. and 12/16/14 at 10:20 a.m., the resident was observed in bed with non-slip socks on his feet and a heel lift cushion in place.</p> <p>The resident's November and December 2014 TARs contained documentation that LNs assessed his skin weekly. An entry on 12/2 included a "2" which indicated a new skin injury/wound. And the last entry on 12/10 included a "1" which indicated no skin injury/wound. The left heel SDTI was not mentioned.</p> <p>"Skin" progress notes dated 10/1/14 - 12/10/14 and Skin Integrity Reports for December 2014 were reviewed. They contained documentation that the left little toe abrasion was found 12/2 and Podus boots were ordered to be worn at all times. Then, on 12/10, "[no] redness" and "Podus boots worn at all times" was noted. The left heel SDTI</p>	F 314			

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F 314	<p>Continued From page 12 was not mentioned.</p> <p>On 12/16/14 at 3:45 p.m., when asked when the resident's left heel SDTI was first discovered, the UM stated, "Yesterday."</p> <p>On 12/16/14 at 4:30 p.m., the DON was informed of concerns about the resident's left heel SDTI. The DON said she research the issue and get back with the surveyors.</p> <p>On 12/17/14 at 11:15 a.m., LN #3 said a "scab" had come off the resident's left heel and "it looks better." Then, at 11:25 a.m., the LN removed the non-slip sock from the resident's left foot. The purplish black area on the left heel was gone and the skin was now pink, intact, and it blanched when the LN pressed on it. The LN stated, "I took his sock off yesterday and there was a dark piece of skin in the sock. And today there was another piece of skin in his sock." When asked if the CNAs check the resident's skin during daily ADLs, the LN stated, "Yes, they should be. But they are not trained like we [nurses] are to assess the skin."</p> <p>On 12/17/14 at 5:30 p.m., the DON was asked for documented evidence that the resident's skin was monitored daily. The DON said daily monitoring was a standard of care and therefore was not documented.</p> <p>The Overview at F314, Pressure Ulcer, stated, "At least daily, staff should remain alert to potential changes in the skin condition and should evaluate and document identified changes." The overview further described a Stage II pressure ulcer as, "Partial thickness loss of dermis presenting as a shallow open ulcer with a</p>	F 314		

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F 314	Continued From page 13 red-pink wound bed without slough. May also present as an intact or open/ruptured blister." Once the purplish black skin came off the resident's left heel, the skin underneath was pink, intact, and blanchable and there was no evidence of deep tissue injury. However, the facility did not provide evidence that the resident's skin was monitored at least daily. It is possible that an blister may have developed, ruptured, and deflated after the skin assessment was done by the LN on 12/10/14 and prior to the discovery of the skin problem by the UM and surveyors on 12/15/14. On 12/17/14 at 6:10 AM, the Administrator, DON, and NC were informed of the PU issue. The facility did not provide any other information regarding the issue.	F 314		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES 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. This REQUIREMENT is not met as evidenced by: Based on staff interview, review of resident records and review of the facility's Risk Management System (RMS) reports and smoking policy, it was determined the facility failed to ensure nursing staff were informed of the need	F 323	<u>F323</u> 1) Resident # 4 had a smoking evaluation completed on or before February 20th 2015 by the Director of Nursing or designee and was found to be safe. Resident # 5 self-care deficit care plan and Kardex was reviewed and updated by the Director of Nursing or designee on or February 20th 2015 for transfer ability. 2) Current resident's that wish to smoke were assessed for smoking needs and completion of smoking evaluation on or before February	

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F 323	<p>Continued From page 14</p> <p>for increased assistance for transfers to prevent a fall with injury. This was true for 1 of 7 sampled residents (#5). Resident #5 was harmed when she fell, sustained a right ankle fracture, and required surgical intervention. Additionally, the facility failed to ensure a resident had been assessed to be safe to smoke without supervision. This was true for 1 of 1 sampled resident (#4). Findings included:</p> <p>1. Resident #5 was admitted to the facility on 10/28/11 and readmitted on 11/12/14 with diagnoses that included aftercare for a lower leg fracture, anxiety state and a history of falls.</p> <p>On 11/8/14 at 8:30 PM Interdisciplinary Progress Notes (IPN) documented the resident received a medication for nausea and vomiting which was ineffective due to "vomiting."</p> <p>An RMS report dated 11/8/14 at 9:00 PM documented a CNA assisted the resident to the restroom due to, "weakness/nausea and vomiting." The resident who was being assisted back to bed, stated she was going to fall and was lowered to the floor by the CNA. Three CNA's then assisted the resident from the floor back to bed. The RMS documented there were no physical injuries.</p> <p>An RMS report dated 11/9/14 documented that after the fall on 11/8/14 at 9:00 PM, the resident needed, "two staff for transfers." The report further documented the resident fell on 11/9/14 at 1:30 AM while being transferred by one staff. The report concluded that the fall resulted in a fracture and dislocation of the resident's right ankle.</p> <p>On 11/9/14 4:45 AM an IPN documented the</p>	F 323	<p>20th 2015 by Director of Nursing or designee.</p> <p>Resident care plans and Kardex were reviewed by the interdisciplinary team on or before February 20th 2015 to ensure care plans and Kardex reflected resident's current status. Care plans and Kardex were updated as indicated by the Director of Nursing or designee on or before February 20th 2015.</p> <p>3) System Changes - Center staff re-educated on or before February 20th 2015 by the Director of Nursing or designee to complete safe smoking evaluations for residents that express desire to smoke.</p> <p>Center staff were re-educated by the Director of Nursing or designee on or before February 20th 2015 regarding shift to shift reporting for updating oncoming shift of change in care and functional status, updating care plans to reflect resident's current status.</p> <p>Care plans and Kardex will be reviewed by the interdisciplinary team during the center morning clinical meeting during a review of including but not limited to the 24 hour report and physician orders.</p>		

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F 323	<p>Continued From page 15</p> <p>resident was not having signs or symptoms of pain or distress related to "recent fall at this time."</p> <p>An Emergency Room Report documented the resident arrived at the local hospital on 11/9/14 at 3:56 PM. The History of Illness section documented an injury to the right ankle that "happened last night." The Physical Exam section stated, "severe tenderness and swelling, small abrasion and moderate deformity consistent with an ankle fracture and dislocated ankle. Limited ROM [range of motion] secondary to pain." The resident's ankle was surgically repaired on 11/10/14.</p> <p>A Summary of Investigation (SI) report, conducted to rule out neglect, documented RN #8 had verbally instructed CNA #9 that the resident was, "a two person assist." Additionally, RN #8 had instructed CNA #9 to inform the "next shift" and had placed the information in the in-service book to be reviewed by nursing staff. The SI identified the change in the resident's care was not documented on the report sheet, the shift notes or the "walking rounds" at shift change.</p> <p>The resident's 10/24/14 Care Plan with a goal to, "improve with ADL function" included interventions added on 11/14/14 to have 2 staff for transfers, bed mobility and toileting.</p> <p>On 12/17/14 at 11:30 AM CNA #10 was observed pushing the resident into her room in a wheelchair. Without assistance of a second staff person, CNA #10 then transferred the resident from her wheelchair to her easy chair.</p> <p>On 12/17/14 at 1:30 PM the DON stated that just prior to the fall that resulted in the fracture, the</p>	F 323	<p>Residents that express desire to smoke will have their medical record reviewed during the center morning clinical meeting during a review of including but not limited to the 24 hour report and physician orders to ensure smoking assessment completed.</p> <p>4) Beginning the week of February 23rd, 2015, Director of Nursing or designee will review 3 admissions per week to ensure smoking evaluation is completed as needed and 3 care plans and Kardex per week for 4 weeks, then monthly for 2 months to ensure self-care deficit care plans and Kardex are reflective of resident's current status. Audit results will be reported to the Performance Improvement Committee for a minimum of 3 months or until compliance sustained.</p> <p>5) The Director of Nursing is responsible for monitoring and compliance.</p> <p>Compliance Date: 02/20/2015</p>	

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F 323	<p>Continued From page 16 .</p> <p>resident told the CNA who was helping her that she preferred a different CNA to assist her. The preferred CNA had not been informed of the change in care requiring two staff to assist the resident. The preferred CNA walked with the resident to the bed with a walker and then the resident fell, which resulted in the fracture.</p> <p>The DON was informed of the observation that took place earlier that day when one CNA transferred the resident. The DON stated there should have been two staff to transfer the resident from the wheelchair to the easy chair. Later that day, the DON provided a "Record of Counseling" for CNA #10 regarding not following the resident's Care Plan. The CNA acknowledged that he knew he should have had a second person to assist with the transfer.</p> <p>On 12/18/14 at 10:15 AM the Administrator and the DON were informed of the above concern. The facility provided no further information.</p> <p>2. Resident #4 was admitted to the facility on 10/3/14 with multiple diagnoses including nontraumatic rupture of Achilles tendon, depression, and anxiety disorder.</p> <p>The resident's 10/10/14 admission MDS documented intact cognition with a BIMS of 13 and tobacco use.</p> <p>The resident's care plan (CP) included the focus area, "...smokes cigarettes and is found to be safe with smoking" created on 10/3/14. Interventions were, "[S]moking materials to be stored by nursing; Report any non compliance with smoking safety rules to MD [physician], responsible party, and administrator; Supervised</p>	F 323		

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F 323	<p>Continued From page 17 smoking per facility policy; Observe for mental status changes that would warrant smoking reassessment; Remind resident to return cigarettes and lighter after smoking break."</p> <p>The resident was interviewed on 12/15/14 from 8:50 to 9:00 a.m. and later that morning from 10:00 to 10:30 a.m. Both times, the resident said she smoked cigarettes. The resident ended the second interview at 10:30 a.m. because it was time for a smoke break.</p> <p>A smoking assessment was not found in the resident's clinical record when it was reviewed on 12/15/14.</p> <p>On 12/15/14 at 1:30 p.m., LN #4 was asked to provide the resident's smoking assessment. The LN looked through the resident's clinical record then said she did not find a smoking assessment but she would keep looking.</p> <p>Later in the afternoon on 12/15/14, the Unit Manager (UM) provided a copy of the facility's 2 page "Policy Statement" which referenced a "Safe Smoking Evaluation" to determine the level of assistance needed: "Assisted Smokers" or "Independent Smokers." The second page of the "Policy Statement" contained the statement, "[blank] acknowledge that I have received a copy of the facility smoking rules" and it included areas for the resident's and a witness' signature. The UM also provided an another copy of the second page of the Policy Statement that was signed by the resident; however, it was not dated or signed by a witness. The UM said she knew a smoking assessment had been done but she had not located it.</p>	F 323		

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F 323	Continued From page 18 On 12/17/14 at 6:10 p.m., the Administrator, DON, and Nurse Consultant were informed of issue. The DON confirmed the facility had not found a Safe Smoking Evaluation for the resident. The facility did not provide any other information regarding the issue.	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, record review and staff interview, it was determined the facility failed to ensure a resident received oxygen (O2) with the appropriate liter flow ordered by the physician. This was true for 1 of 7 sampled residents (#2). Improper liter flow has the potential for harm if a resident experiences dizziness or light headedness and could lead to pulmonary edema. Findings included: Resident #2 was admitted to the facility on 11/6/14 with diagnoses that included schizophrenia, chronic airway obstruction and bipolar disease.	F 328	F328 1) Resident # 2 was assessed by Director of Nursing or designee on or before February 20th 2015 for any adverse effects related to oxygen administered at 4 liters per min. No adverse findings noted at time of assessment Physician was notified of oxygen administration on January 20 th 2015 with no new orders. Family was notified on January 20 th 2015. 2) Residents currently receiving oxygen therapy were reviewed on or before February 20th 2015 by Director of Nursing or Designee to ensure resident receiving the oxygen as ordered. 3) System Changes - Licensed nursing were re-educated by the Director of Nursing or designee on or before February 20th 2015 regarding oxygen administration per physician orders and increased monitoring schedule.	

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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 12/18/2014
NAME OF PROVIDER OR SUPPLIER REXBURG CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 860 SOUTH SECOND STREET 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 328	Continued From page 19 The resident's record included a 11/7/14 physician's order for O2 at 3 liters per minute (lpm) via a nasal cannula continuously for chronic airway obstruction. On 12/15/14 at 9:00 AM the resident was observed wearing a nasal cannula attached to the O2 concentrator which was at 4 lpm. The resident left for a physician appointment at 9:40 AM. When she returned, with nasal cannula in place, the portable O2 tank was observed at 3 lpm. However, at 1:30 PM on 12/15/14 she was observed wearing the nasal cannula attached to the concentrator which was at 4 lpm. On 12/17/14 at 1:30 PM the DON was asked about the above concern. The DON stated the physician order for oxygen at 3 lpm should have been followed.	F 328	Residents receiving oxygen will have verification of administration increased from twice daily to four times daily for increased monitoring. 4) Beginning the week of February 23 rd , 2015, Director of Nursing or designee will review 5 residents receiving oxygen therapy per week for 4 weeks, then monthly for 2 months to ensure oxygen administration accuracy. Audit results will be reported to the Performance Improvement Committee for a minimum of 3 months or until compliance sustained. 5) The Director of Nursing is responsible for monitoring and compliance. Compliance Date: 02/20/2015	
F 329 SS=E	483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. 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	F 329	F329 1) Resident # 2 medications were reviewed by physician and justification for use received on January 8 th 2015. Resident #2 care plan and behavior monitor sheet was reviewed by the interdisciplinary team. Care plan updated to include behaviors that are observable and measureable by the Director of	

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F 329	<p>Continued From page 20</p> <p>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 record review and staff interview, it was determined the facility failed to ensure 4 of 9 sample residents (#s 2, 3, 6, & 9) were free from unnecessary medications. The facility failed to ensure justification for use of psychopharmacological medication; failed to monitor behaviors related to its use; and, failed to provide justification for duplicate therapy. This practice placed residents at risk for unanticipated declines or newly emerging or worsening symptoms. Findings included:</p> <p>1. Resident #2 was admitted to the facility on 11/6/14 with diagnoses which included schizophrenia, depressive disorder and bipolar disease.</p> <p>The resident's physician orders included orders for Nortiptyline HCL (antidepressant) 50 mg at bedtime for depression, Venafaxine HCL ER (antidepressant) 150 mg every morning for depression and Abilify (antipsychotic) 15 mg at bedtime for depression. All of the medications had a start date of 11/6/14.</p> <p>a. The resident's medical record did not include</p>	F 329	<p>Nursing or designee on or before February 20th 2015.</p> <p>Resident # 6 care plan and behavior monitor was reviewed by the interdisciplinary team on or before February 20th 2015. Care plan was updated to include behaviors that are observable and measureable by the Director of Nursing or designee.</p> <p>Resident # 9 medications were reviewed by the medical doctor. New orders were received on January 5th 2015. On or before February 20th 2015 the Director of nursing or designee notified family of medication changes and care plan was updated to reflect current changes.</p> <p>Resident # 3 care plan and behavior monitor were reviewed by the interdisciplinary team on or before February 20th 2015. Care plan was updated on or before February 20th 2015 by the Director of Nursing or designee. Physician reviewed medications and justification for the continued use was completed on or before February 20th 2015.</p> <p>2) Residents receiving duplicate therapy of psychotropic medications had reviews of behavior monitors completed by the interdisciplinary</p>	

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F 329	<p>Continued From page 21 justification for the use of two antidepressants.</p> <p>On 12/17/14 at 1:30 PM, the Support Services Director and the DON were asked to provide justification for the use of two antidepressants. The facility provided no further information.</p> <p>b. The resident's 11/14/14 care plan to "Not vocalize feeling down..." documented a goal for the resident to not exhibit crying, vocalizations of feeling down, tearfulness and isolation. The care plan did not include how isolation would be exhibited such as staying in bed, not attending favorite activities, etc.</p> <p>A Behavior Monitoring sheet (BMS) for November 2014 had an area to document "verbalizes feeling down"; however, it did not identify how that behavior was displayed. Zero incidents were documented for the month. The BMS did not include places to document the behavior of isolation (or how exhibited), crying or tearfulness.</p> <p>The BMS for 12/1/14 through 12/14/14 documented 0 incidents of withdrawal or vocalizing feeling down. These behaviors were not defined.</p> <p>On 12/17/14 at 1:30 PM the Support Services Director (SSD) was informed the behaviors identified on the BMS were not observable or measurable. The Support Services Director stated the resident had a history of not going to activities and not eating in the dining room when she was depressed. NOTE: These are observable and measurable behaviors.</p> <p>2. Resident #6 was admitted to the facility on 6/19/13 with diagnoses that included muscular</p>	F 329	<p>team on or before February 20th 2015. New MD orders and/or Justifications of use were received by Director of Nursing or designee at time of reviews.</p> <p>Resident's receiving antidepressant and anti-psychotic medications had care plans and behavior monitor reviewed by the interdisciplinary team on or before February 20th 2015. Care plan and behavior monitors were updated by the Director of Nursing or designee on or before February 20th 2015 for observable and measurable behaviors.</p> <p>3) System Changes - Social Service Director was re-educated by the Director of Nursing or designee on or before February 20th 2015 regarding receiving justification for duplicate therapy for psychotropic medications.</p> <p>Social Service Director and licensed nurses were re-educated by the Director of Nursing or designee on or before February 20th 2015 regarding documentation of observable and measurable behaviors.</p> <p>Resident's records will be reviewed during the center morning clinical meeting during a review of including</p>		

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F 329	<p>Continued From page 22 wasting, impulse control disorder and bipolar disorder.</p> <p>The resident's 12/2/14 physician Order Summary Report included an order for Bupropion HCL (antidepressant) 300 mg every day for depression with a start date of 9/14/14.</p> <p>a. The resident's care plan documented a goal of, "Continued Self Care Deficit r/t (related to) anxiety and depression..." which was initiated on 8/16/11. The Intervention section documented to, "reinforce success for task accomplished." The care plan did not include any other information, including how this would be measured.</p> <p>The BMS' for the October 1 - December 14, 2014 documented 0 incidents of "vocalizes feeling down."</p> <p>On 12/17/14 at 1:30 PM the SSD stated that neither the care plan nor BMS included information regarding how the depression was exhibited or interventions for staff to implement. The SSD Director stated the BMS' documented statements of, "feeling down."</p> <p>b. Resident #6's 6/17/11 care plan had goals which included to not, "...pull her urostomy...thinking people are stealing from her or hearing voices ..." The Intervention section documented staff were to give the resident positive praise and to "not feed into her negative behaviors." The Intervention section did not include any other information as to what "feed into her behaviors" meant such as to redirect to a preferred activity, ignore and talk with the resident about her day etc. Additionally, the Intervention section documented Social Services was to visit</p>	F 329	<p>but not limited to the 24 hour report and physician orders following admission and with quarterly updates to ensure gradual dose reduction requested and justification from physician for dual psychotropic therapy in conjunction with monthly interdisciplinary psychotropic review.</p> <p>4) Beginning the week of February 23rd, 2015, Director of Nursing or designee will review 2 residents receiving antidepressant and anti-psychotic medications per week for 4 weeks, and then monthly for 2 months to ensure justification for use is in place for dual therapy. Audit results will be reported to the Performance Improvement Committee for a minimum of 3 months or until compliance sustained. The Director of Nursing is responsible for monitoring and compliance.</p> <p>Beginning the week of February 23rd, 2015, Director of Nursing or designee will review 5 behavior care plans and 5 behavior monitor per week for 4 weeks, and then monthly for 2 months to ensure care plans and behavior monitoring sheets are reflective of resident's current status including observable and measurable behaviors. Audit results</p>	

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F 329	<p>Continued From page 23</p> <p>with Resident #6 as needed. It did not identify when "as needed" would apply such as, when the resident was exhibiting signs of depression, 3 times a week to evaluate the resident's depression, etc.</p> <p>The BMS for October 1 -December 14, 2014, had an area to document hallucinations but the behaviors of pulling on her urostomy, thinking people were stealing from her or hearing voices were not listed on the BMS.</p> <p>On 12/17/14 at 1:30 PM the SSD stated the resident did not currently exhibit behaviors of pulling on her urostomy. When asked if the resident had delusions of people stealing from her, the SSD stated the resident had hallucinations and realized they were not real. The SSD stated she did visit with the resident almost daily but did not document the visits. Without criteria or documentation of the social services visits, it could not be determined if the visits were consistently implemented or if they were effective.</p> <p>3. Resident #9 was admitted to the facility on 11/18/14 with a diagnosis of depression.</p> <p>The resident's 12/2/14 physician Order Summary Report included orders for Cymbalta (antidepressant) 30 mg every morning for depression (start date 11/21/14) and Zolof (antidepressant) 50 mg at bedtime for depression (start date 11/18/14).</p> <p>The resident's medical record did not include justification for the duplicate therapy.</p> <p>On 12/18/14 at 10:15 AM the Administrator and</p>	F 329	<p>will be reported to the Performance Improvement Committee for a minimum of 3 months or until compliance sustained.</p> <p>5) The Director of Nursing is responsible for monitoring and compliance.</p> <p>Compliance Date: 02/20/2015</p>		

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F 329	<p>Continued From page 24</p> <p>the DON were informed of the above concerns. The facility provided no further information.</p> <p>4. Resident #3 was admitted to the facility on 6/4/12 with multiple diagnoses including bi-polar affective disorder and schizophrenia. Findings include:</p> <p>The resident's Order Summary Report, dated 12/2/14, included "Active" orders for the antipsychotic medication thioridazine hydrochloride 100 milligrams (mg) by mouth 2 times a day and 125 mg at bedtime for schizophrenia dated 9/12/14.</p> <p>The resident's care plan, initiated 10/7/14, included the focus area, "Exhibits paranoid/suspicious behavior, and hallucinations aeb (as evidenced by) talking to people who aren't there related to...schizophrenia." Goals included "...will not exhibit more than 1 episode of hallucinations or paranoia per month for the next 90 days." Interventions included, "Administer thioridazine per order...thioridazine decreased to 100 mg po [by mouth] every tid [3 times a day] on 7/18/13...[t]hioridazine was changed back to 100 mg bld [2 times a day] and 125 mg every hs [bedtime] after a failed attempt to reduce on 8/28/13...Track behaviors on behavior tracking sheets every shift." The care plan did not include how paranoid/suspicious behavior would be exhibited.</p> <p>The resident's Behavior Monitoring and Interventions forms for 10/1/14 through the day shift on 12/15/14 documented 0 hallucinations. However, the behavior monitors did not include paranoid/suspicious behavior.</p>	F 329			

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F 329	<p>Continued From page 25</p> <p>An 8/26/14 pharmacy Consultation Report to the physician and the DON regarding the resident's thioridazine recommended, "If this medication is to continue at this dose, please provide a statement of risk versus benefit." The rationale for the recommendation was, "The 2012 American Geriatrics Society Beers Criteria recommends avoiding thioridazine in older adults due to an increased risk for QT-interval prolongation [heart rhythm problem] and highly anticholinergic side effects..."</p> <p>The Consultation Report included an area for the physician's response and 3 options to choose from: accept the recommendation(s), accept the recommendation(s) with modifications, or decline the recommendations(s) and do not wish to implement any changes due to the reasons below." On 9/2/14, the physician declined the pharmacist recommendations and wrote, "Failed Reduction."</p> <p>The resident's 11/25/14 Psychotherapeutic Medication Use Evaluation form included the thioridazine 100 mg 2 times a day and 125 mg at bedtime. It documented the antipsychotic medication was started 6/4/12 and, "Last Dosage Change Date: 8-28-13 increase [after] failed attempt to reduce." It also documented "hallucinations = 0" in the last 30 days. Paranoid/suspicious behavior, however, was not mentioned.</p> <p>On 12/17/14 at 5:00 p.m., the Director of Social Services (DSS) was interviewed. When asked why a dose reduction for thioridazine had not been attempted since August 2013, the SSD stated, "The resident came to us from a facility that had tried dose reductions without positive</p>	F 329			

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F 329	Continued From page 26 results and the physician does not want to attempt any other dose reductions." The resident's clinical record did not contain evidence that paranoid/suspicious behavior was monitored or provide adequate justification for the continued use of thioridazine at the current dose. The last documented attempt to gradually reduce the dose of thioridazine was 7/18/13, or 17 months ago. On 12/17/14 at 6:10 p.m., the Administrator, DON, and Nurse Consultant were informed of the surveyor's findings. The facility did not provide any other information which resolved the issue.	F 329		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors.	F 356	F356 1) Staffing hours posted at time of identification on December 14 th 2014 by the Nurse Practice Educator. 2) Posting of staffing hours was reviewed in resident council by Director of Nursing or Designee on or before February 20th 2015. Resident's did not voice any concerns related to staffing hours not being posted. 3) Licensed nurses were re-educated by the Director of Nursing or designee on or before February 20th 2015 regarding posting of staffing hours daily. 4) Beginning the week of February 23 rd , 2015, Director of Nursing or	

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F 356	Continued From page 27 The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to post current nurse staffing information which had the potential to affect 10 of 10 sample residents (#s 1-10), all other residents who lived in the facility, and visitors who came into the facility. Findings included: On 12/14/14 at 4:40 PM, the posted Daily Nurse Staffing Form information was observed on a wall by the 200 hall nurses' station. However, the information was documented as printed "11/30/2014 at 7:09:17 PM" for "Tuesday 12/02/2014." The information was 14 days old. The Nurse Practice Educator (NPE) was immediately asked about the outdated nurse staffing information and she confirmed that it was old. Per the surveyors' request, the NPE provided a copy of the outdated information. The NPE then printed the Daily Nurse Staffing Forms for 12/13/14 and 12/14/14. When asked if the nurse staffing information for 12/13/14 had been posted anywhere, the NPE stated, "No. It's right here (she pointed to printer)." Upon request, the NPE also provided copies of the nurse staffing	F 356	designee will review posted staffing hours 3 times per week for 4 weeks, then monthly for 2 months to ensure staffing hours are posted. Audit results will be reported to the Performance Improvement Committee for a minimum of 3 months or until compliance sustained. 5) The Director of Nursing is responsible for monitoring and compliance. Compliance Date: 02/20/2015		

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F 356	Continued From page 28 information for 12/13/14 and 12/14/14 which she had just printed. On 12/15/14 at 1:30 PM, the posted Daily Nurse Staffing Form was observed with the current information. On 12/16/14 at 5:30 PM, the Administrator, DON, and Nurse Consultant were informed of the issue. The facility did not provide any other information regarding the issue.	F 356		
F 371 SS=E	483.35(I) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure the frame of the meat slicer directly under the blade, a mixer bowl, and an oven door were clean. These failures created the potential for contamination of food and exposed 9 of 10 sample residents (#s 1-7, 9 and 10) and all other residents who ate food prepared in the kitchen to be potential sources of disease causing pathogens. Findings included:	F 371	F371 1) On or before February 20th 2015 the oven door, the slicer and the mixing bowl was cleaned by Food Service Director or designee. 2) Kitchen sanitation audit was completed by the center Administrator or designee on or before February 20th 2015. Any findings were corrected at time of inspection. 3) Dietary staff were re-educated by the Center Administrator or designee on or before February 20th 2015 regarding policy for cleaning kitchen appliances. 4) Beginning the week of February 23 rd , 2015, Facility Administrator or designee will complete weekly sanitation audit of slicer, stand mixer and oven for 4 weeks, then monthly	

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NAME OF PROVIDER OR SUPPLIER REXBURG CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 660 SOUTH SECOND STREET 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 371	<p>Continued From page 29</p> <p>On 12/14/14 at 3:50 p.m., during the initial tour of the kitchen with the evening cook in attendance, the following was observed:</p> <ul style="list-style-type: none"> * Two "gooey" light brown substances were on the meat slicer frame directly under the blade. Each one was about 1/4 inch long by 1/4 inch wide by 1/8 inch high. * A dry, rust colored flake of an unidentified substance the size of a bran flake was in the bowl of the small mixer. * A sticky brown substance was on the right door of the double ovens. The sticky substance covered approximately 2 inches at each end on the top of the door and it extended 3/4 of the way down the inside of the door on the left. <p>The cook said she had not used the meat slicer or the small mixer that day and regarding the ovens, she stated, "We never use them." When asked if the meat slicer, the mixer bowl, and the oven were supposed to be clean, the cook stated, "Yes." The cook said the substances on the meat slicer looked like "meat" to her.</p> <p>On 12/16/14 at 10:55 a.m., the aforementioned unclean items were observed to have been cleaned.</p> <p>On 12/17/14 at 6:10 p.m., the Administrator, DON, and Nurse Consultant were informed of the kitchen issues. The facility did not provide any other information regarding the issues.</p>	F 371	<p>for 2 months to ensure appliances are cleaned per policy. Audit results will be reported to the Performance Improvement Committee for a minimum of 3 months or until compliance sustained.</p> <p>5) The Center Administrator is responsible for monitoring and compliance.</p> <p>Compliance Date: 02/20/2015</p>		
F 431 SS=E	<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</p>	F 431	<p>F431</p> <p>1) Licensed nurses including nurse caring for resident #12, were re-educated by the Director of Nursing</p>		

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F 431	<p>Continued From page 30</p> <p>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 package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure a controlled medication (med) was properly stored, med labels matched physician orders, and meds had expiration dates and/or were not expired. This was true for 3 of 9 sample residents (#'s 4,</p>	F 431	<p>or designee on or before February 20th 2015 regarding procedure for proper storage and destruction of a controlled medication, including but not limited to duragesic patches.</p> <p>Resident # 9 was assessed by Director of Nursing or designee on or before February 20th 2015 for any adverse effects related to medication label error. No findings at time of assessment. Physician and family were notified on medication label error. New bottle of Lantus was received from pharmacy with correct time of administration on or before February 20th 2015.</p> <p>Resident # 8 was assessed by the Director of Nursing or designee on or before February 20th 2015 for any adverse effects related to medication label error with no findings at the time of assessment. Physician and family notified of medication label error. New physician order received on December 17th 2015 for medication administration.</p> <p>On or before February 20th 2015 the pyxis machine was audited to ensure no expired medication by the Director of Nursing or designee.</p>	

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F 431	<p>Continued From page 31</p> <p>8, & 9) during med pass observations and med storage inspections and for 1 random resident (#12). These failures created the potential for: a) diversion of Resident #12's unsecured used fentanyl patch if it was picked up by a resident or staff; b) Resident #8 to receive a med by the wrong route; c) Resident #9 to receive insulin at the wrong time; and, sub-optimal efficacy if: d) Resident #4's undated meds were expired; or, e) a resident received an expired med. Findings included:</p> <p>1. On 12/15/14 at 4:40 p.m., 2 surveyors observed as LN #1 poured meds into a med cup for a resident and as a CNA walked up and handed the LN a used fentanyl patch (a controlled long acting pain medicine that is absorbed through the skin). The CNA said Resident #12 had just removed the patch. LN #1 placed the used fentanyl patch on top of the medication (med) cart. The LN then placed the med cup with meds in it in a med cart drawer then she unlocked the controlled meds drawer and got a new fentanyl patch for Resident #12. The LN locked the med cart then she took the new fentanyl patch to Resident #12's room and administered it to the resident (the resident said the old patch "came off" when she scratched herself). However, the LN did not secure the used fentanyl patch before she left the med cart and went into Resident #12's room.</p> <p>As the surveyors left Resident #12's room, a CNA and a resident were observed in the hallway in the vicinity of the med cart. And, when the surveyors returned to the med cart, the DON walked by. The DON was shown the unsecured fentanyl patch on top of the med cart and she acknowledged it by nodding her head. Moments</p>	F 431	<p>Medications returned to pharmacy as indicated through review.</p> <p>Resident # 4 was assessed by the Director of Nursing or designee on or before February 20th 2015 for any adverse effects related to no expiration on pre-packaged bi-fold pack of medications with no findings at the time of assessment. Medications were returned to pharmacy and new bubble packs of medication were received with expiration dates.</p> <p>2) Licensed nurse competencies were completed by the Director of Nursing or designee on or before February 20th 2015 to ensure the five rights of medication administration were followed.</p> <p>Residents currently residing in the facility medications were reviewed to ensure that the label matched medication administration record by the Director of Nursing or designee on or before February 20th 2015.</p> <p>On or before February 20th 2015, residents current medications and over the counter medications were reviewed by the Director of Nursing or designee to ensure no expired medications were present.</p>	

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F 431	<p>Continued From page 32</p> <p>later, LN #1 returned to the med cart. When asked about the unsecured fentanyl patch, LN #1 stated, "I have to waste it with another nurse." The LN then asked the DON to assist her to waste the used patch. The DON agreed and they wasted it a few minutes later.</p> <p>The used fentanyl patch was unsecured and unattended when it was on top of the med cart while LN #1 was in Resident #12's room.</p> <p>Note: Informational Letter, Reference: S&C: 13-02 NH, stated, 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...in order to minimize loss or diversion...</p> <p>One benefit of the patch is the continuous delivery of fentanyl over 72 hours...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 overdose...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>	F 431	<p>Residents current medications were reviewed to ensure that there are expiration dates on all medications on or before February 20th 2015 by the Director of Nursing or designee.</p> <p>Residents currently receiving duragesic patches were reviewed for appropriate medication storage on or before February 20th 2015 by the Director of Nursing or designee.</p> <p>3) System Change - Licensed nursing were re-educated by the Director of Nursing or designee on or before February 20th 2015 regarding procedure for storage and wasting a controlled substance, including but not limited to duragesic patches.</p> <p>Licensed nursing were re-educated by the Director of Nursing or designee on or before February 20th 2015 regarding procedure for a medication change and the pharmacy label on medications with placement of sticker from the pharmacy to indicate a change in medication orders.</p> <p>Licensed nursing were re-educated by the Director of Nursing or designee on or before February 20th 2015 regarding the five rights of medication administration. Licensed</p>	

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F 431	<p>Continued From page 33</p> <p>2. On 12/16/14 at 4:10 p.m., LN #3 was observed as she drew up 16 units of Lantus insulin for Resident #9. The pharmacy label for the Lantus read, "Inject 16 units subcutaneously at each bedtime." The LN was about to go into the resident's room with the syringe in her hand when she was asked about the time the insulin was to be given. The LN said Lantus was scheduled for 4 p.m. and it had always been given at 4 p.m. The LN showed 2 surveyors the resident's MAR which documented Lantus was scheduled for 4 p.m. daily. Then, the LN administered the Lantus to the resident.</p> <p>Review of the resident's clinical record revealed the following Lantus insulin orders: * 11/18/14 "active" physician order - "one time a day;" and, * 11/17/14 Physician Discharge Medication Orders form - "4 p.m." This order was "noted 11/18/14" by a facility LN.</p> <p>The Lantus pharmacy label did not match either of the aforementioned physician orders.</p> <p>On 12/17/14 at 6:10 p.m., the Administrator, DON, and Nurse Consultant were informed of the medication labeling issue.</p> <p>On 12/22/14 at 4:43 p.m., the Bureau of Facility Standards received a 5 page facsimile (fax) from the facility.</p> <p>The fax included an "Order Details" form, dated 11/18/14, for Resident #9's Lantus insulin. It documented, "Lantus...Inject 16 units subcutaneously one time a day..." and "Scheduling Details...Frequency: one time a day...Facility Time Code: QD 4 p [every day at</p>	F 431	<p>nurses also completed competencies to ensure rights are followed.</p> <p>Licensed nursing were re-educated by the Director of Nursing or designee on or before February 20th 2015 regarding checking expiration dates on medications.</p> <p>A monthly review of the center's medications including those in medications carts and pyxis will be completed with a log to verify any future expiration dates for destruction of medication. A verification check of medications has been added to ensure labels match medication administration record at time of delivery from pharmacy.</p> <p>Current licensed nursing competencies on medication storage and destruction of controlled substances will be completed quarterly and upon hire to ensure proper procedure.</p> <p>4) Beginning the week of February 23rd, 2015, Director of Nursing or designee will observe 3 storage and destruction of controlled substances per week for 4 weeks, then monthly for 2 months to ensure proper management of controlled substances.</p>		

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F 431	<p>Continued From page 34 4:00 p.m.]"</p> <p>Handwritten at the bottom of the form was, "Our orders match the admission orders. The re-cap [recapitulation] prints the schedule type but do [emphasis added] match the order. The label did not [emphasis added] match the Admiss[ion], recap & current order."</p> <p>3. On 12/17/14 at 8:00 a.m., LN #4 was observed as she poured 8 meds (7 pills and tablets and 1 liquid) for Resident #8. The meds included chlorthalidone [for high blood pressure]. The chlorthalidone pharmacy label read, "Chlorthalidone 25 milligram [mg] tablet...Give 1/2 tab (12.5 mg) by mouth every day." The LN administered all 8 of the medications via the resident's gastrostomy tube.</p> <p>Review of the resident's Order Summary Report, dated 12/2/14, revealed an 11/12/14 "Active" order for chlorthalidone to be administered "enterally," which meant via the gastrostomy tube.</p> <p>The pharmacy label on the chlorthalidone bubble pack did not match the physician's order.</p> <p>4. On 12/17/14 at 3:00 p.m., during an inspection of the facility's PYXIS (medication storage system) with the Unit Manager (UM) present, the following expired medications (meds) were found: - 3 Metoclopramide (for nausea) 10 mg tablets - expired 6/14; - 3 Diphenhydramine (antihistamine) 50 mg/ml (milligrams per milliliter) vials (for injection) - expired 10/14; - 2 Naloxone (antidote, opioid antagonist) 0.4 mg/ml vials - expired 8/14; - 3 Clonidine (antihypertensive) Transdermal 0.1</p>	F 431	<p>Beginning the week of February 23rd 2015 the Director of Nursing or designee will audit 3 medication passes per week for 4 weeks, then monthly for 2 months to ensure proper medication administration.</p> <p>Beginning the week of February 23rd 2015 the Director of Nursing or Designee will audit the pyxis machine 1 time per week for 4 weeks, then monthly for 2 months to ensure no expired medications.</p> <p>Beginning the week of February 23rd 2015, the Director of Nursing or designee will audit 5 medication cards per week for 4 weeks, then monthly for 2 months to ensure expiration dates in place. Audit results will be reported to the Performance Improvement Committee for a minimum of 3 months or until compliance sustained.</p> <p>5) The Director of Nursing is responsible for monitoring and compliance.</p> <p>Compliance Date: 02/20/2015</p>	

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F 431	<p>Continued From page 35</p> <p>mg patches, expired 8/14; - 7 Potassium (supplement) 10 meq (milliEquivalent) tablets - expired 10/14; - 7 Geodon (antipsychotic) 20 mg tablets - expired 6/14; - 10 Detrol (urinary antispasmodic) 2 mg tablets - expired 9/14; and, - 2 Sodium Polystyrene sulfonate (potassium removing resin) 15 gm/60 ml (15 grams per 60 milliliters) suspensions - expired 9/14.</p> <p>The UM indicated that she would contact the pharmacy and return the expired meds right away.</p> <p>5. On 12/17/14 at 3:30 p.m., during an inspection of med cart #2 with the Unit Manager (UM) in attendance, a pre-packaged bi-fold pack of medications for Resident #4 was found without any expiration dates. Attached to the bi-fold pack was a list of following medications: amlodipine (antianginal/antihypertensive properties), potassium chloride (supplement), loratadine (antihistamine), losartin/hydrochlorothiazide (antihypertensive), omeprazole (reduces stomach acid production), fluoxetine (antidepressant), metoprolol (antihypertensive), clonazepam (anticonvulsant), metformin (antidiabetic), atorvastin (reduces cholesterol), and trazodone (antidepressant). The UM said the resident's personal pharmacy sent the resident's pre-packaged meds to the facility every week. When asked when the meds expired, the UM confirmed there were no expiration dates for any of the meds. The UM said she would contact the resident's pharmacy about the issue.</p> <p>On 12/17/14 at 6:10 p.m., the Administrator, DON, and Nurse Consultant were informed of the</p>	F 431		

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F 431	Continued From page 36 labeling issue regarding Resident #8's chlorthalidone, the expired meds in the PYXIS, and Resident #4's pre-packages meds without expiration dates. The facility did not provide any other information regarding these issues.	F 431			
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.	F 441	<u>F441</u> 1) Resident # 3 was assessed by Director of Nursing or designee on or before February 20th 2015 for any adverse reactions related to improper procedure for performing hand hygiene. No adverse findings noted at the time of assessment. Resident # 9 was assessed by the Director of Nursing or designee on or before February 20th 2015 for any adverse reactions related to improper procedure for performing hand hygiene and no gloves worn during insulin administration. No adverse findings noted at the time of assessment. Resident # 12 was assessed by the Director of Nursing or designee on or before February 20th 2015 for any adverse reactions related to improper procedure for performing hand hygiene. No adverse findings noted at the time of assessment. 2) No other resident's exhibit signs and symptoms of infections related to cross contamination. To ensure no		

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F 441	<p>Continued From page 37</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure staff performed hand hygiene prior to and/or between assisting 2 of 7 sample residents (#s 3 and 9), and one random resident (#12). The deficient practice had the potential to cause harm if residents developed infections from cross contamination. Findings include:</p> <p>1. On 12/15/14 at 9:30 AM, CNA #1 was observed providing ADL care to Resident #3. The CNA wiped food residue from around the resident's mouth, wiped the rest of his/her face and then wiped the resident's eyes using the same wash cloth. The CNA removed her gloves; however, she failed to wash or sanitize her hands before she left the resident's room.</p> <p>2. On 12/15/14 at 9:45 AM, the Unit Manager/Infection Control LN was observed as she removed Resident #3's protective boots and socks without wearing protective gloves. The LN then touched the resident's left lateral ankle and heel, and the right foot with her bare hands as she checked the skin for blanching. After the assessment, the LN did not perform any type of hand hygiene before she picked up the resident's water cups and left the room.</p> <p>3. On 12/15/14 at 4:30 PM, LN #1 was observed</p>	F 441	<p>possible cross contamination to other residents, CNA hand washing competencies were completed by the Director of Nursing or designee on or before February 20th 2015 to ensure hand hygiene performed before and after care provided.</p> <p>A review of resident receiving blood glucose and insulin injections were reviewed by the Director of Nursing or designee for potential cross contamination on or before February 20th 2015 to ensure hand hygiene and use of gloves performed before and after procedure.</p> <p>Licensed nurse medication administration competencies completed by the Director of Nursing or designee on or before February 20th 2015 to ensure hand hygiene performed between resident care.</p> <p>3) Nursing staff were re-educated by the Director of Nursing or designee on or before February 20th 2015 regarding procedure for performing hand hygiene and use of gloves before and after resident care, when administering injections, between resident care when coming in contact with bodily fluids.</p> <p>4) Beginning the week of February 23rd, 2015, Director of Nursing or</p>	

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

PRINTED: 01/16/2015
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 12/18/2014
NAME OF PROVIDER OR SUPPLIER REXBURG CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 660 SOUTH SECOND STREET WEST REXBURG, ID 83440		
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F 441	Continued From page 38 testing Resident #9's blood glucose (BG) level. LN #1 did not perform hand hygiene before or after the BG. Nor did she wear protective gloves during the procedure. After the BG test, the LN left the room and returned to the Medication (MC) parked outside the resident's room. Almost immediately, a CNA handed the LN a fentanyl patch and said Resident #12 had just scratched it off. The LN took the patch and placed it on top of the MC, then she checked out a new fentanyl patch and went directly to Resident #12 and applied the new patch. The LN did not perform any hand hygiene or wear protective gloves between contact with Resident #9 and #12. The LN returned to the MC once more and drew up 2 insulin doses for Resident #9, then she administered the insulin to the resident, again without performing hand hygiene or wearing protective gloves. On 12/18/14 at 10:30 AM, the Administrator and DON were informed of the observations regarding infection control. The facility did not provide any additional information regarding the issues.	F 441	designee will perform hand hygiene competencies with 5 staff members and 3 blood glucose and insulin injection competencies per week for 4 weeks, and then monthly for 2 months to ensure hand hygiene and gloves are being completed per policy. Audit results will be reported to the Performance Improvement Committee for a minimum of 3 months or until compliance sustained. 5) The Director of Nursing is responsible for monitoring and compliance. Compliance Date: 02/20/2015		

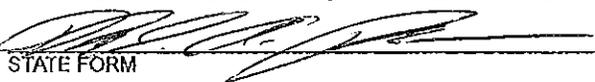
Bureau of Facility Standards

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 12/18/2014
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C 000	16.03.02 INITIAL COMMENTS The following deficiencies were cited during the State licensure survey of your facility. The surveyors conducting the survey were: Sherri Case, BSW, LSW, QIPD, Team Coordinator Linda Kelly, RN Kirsti Stephenson, RN	C 000		
C 234	02.106,03,c Unsupervised Smoking by Residents c. That unsupervised smoking by patients/residents not mentally or physically responsible is prohibited. This includes patients/residents affected by medication. This Rule is not met as evidenced by: Please refer to F-323 as it relates to the facility's failure to assess a residents safety when smoking.	C 234	<u>C234</u> Please refer to POC for F323	
C 325	02.107,08 Food Sanitation 08. Food Sanitation. The acquisition, preparation, storage, and serving of all food and drink in a facility shall comply with Idaho Department of Health and Welfare Rules, Title 02, Chapter 19, "Rules Governing Food Sanitation Standards for Food Establishments (UNICODE)." This Rule is not met as evidenced by: Refer to F371 as it related to sanitary conditions in the kitchen.	C 325	<u>C325</u> Please refer to POC for F371	
C 644	02.150,01,a,i Handwashing Techniques a. Methods of maintaining	C 644	<u>C644</u> Please refer to POC for F441	

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



TITLE

Administrator

(X0) DATE

2-12-15

Bureau of Facility Standards

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C 644	Continued From page 1 sanitary conditions in the facility such as: i. Handwashing techniques. This Rule is not met as evidenced by: Refer to F441 as it related to hand hygiene.	C 644		
C 745	02.200,01,c Develop/Maintain Goals/Objectives c. Developing and/or maintaining goals and objectives of nursing service, standards of nursing practice, and nursing policy and procedures manuals; This Rule is not met as evidenced by: Refer to F281 as it related to standards of practice regarding blood glucose monitoring.	C 745	<u>C745</u> Please refer to POC for F281	
C 782	02.200,03,a,iv Reviewed and Revised iv. Reviewed and revised as needed to reflect the current needs of patients/residents and current goals to be accomplished; This Rule is not met as evidenced by: Please refer to F-280 as it relates to care plan revisions.	C 782	<u>C782</u> Please refer to POC for F280	
C 788	02.200,03,b,iv Medications, Diet, Treatments as Ordered iv. Delivery of medications, diet and treatments as ordered by the attending physician, dentist or nurse practitioner; This Rule is not met as evidenced by: Refer to F328 as it relates to following physician orders for oxygen therapy.	C 788	<u>C788</u> Please refer to POC for F328	

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C 789	Continued From page 2	C 789	<u>C789</u>	
C 789	02.200,03,b,v Prevention of Decubitus 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: Refer to F314 as it related to pressure ulcers.	C 789	Please refer to POC for F314 <u>C790</u>	
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: Refer to F323 as it relates to preventing accidents.	C 790	Please refer to POC for F323	
C 821	02.201,01,b Removal of Expired Meds b. Reviewing all medications in the facility for expiration dates and shall be responsible for the removal of discontinued or expired drugs from use as indicated at least every ninety (90) days. This Rule is not met as evidenced by: Refer to F431 as it related to expired medications and medications without expiration dates.	C 821	<u>C821</u> Please refer to POC for F431	
C 832	02.201,02,f Labeling of Medications/Containers f. All medications shall be labeled with the original prescription legend including the name and address of the	C 832	<u>C832</u> Please refer to POC for F431	

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C 832	Continued From page 3 pharmacy, patient's/resident's name, physician's name, prescription number, original date and refill date, dosage unit, number of dosage units, and instructions for use and drug name. (Exception: See Unit Dose System.) This Rule is not met as evidenced by: Refer to F431 as it related to medication prescription labels.	C 832		
C 833	02.201,02,g No Alteration of Original Legend g. No alteration or replacement of original prescription legend shall be allowed. This Rule is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure an original medication prescription legend was not altered. This was true for 1 of 25 pharmacy labels reviewed for 1 of 7 residents (#8) during medication pass observations. The failure created the potential for medication errors. Findings include: On 12/17/14 at 8:00 a.m., Resident #8's ciprofloxacin prescription label (legend) was noted to have been altered. The label read, "Ciprofloxacin...1 tab[let] by mouth twice daily for 5 days." A line was drawn through the word mouth. Underneath the crossed out word in handwriting was, "Peg [sic, PEG or percutaneous endoscopic gastrostomy] tube" and an initial with a circle around it. LN #4, who was present at the time, was asked who had changed the prescription label. She stated, "We did because it said by mouth." When asked who "we" was, the	C 833	<p><u>C833</u></p> <p>1) On or before February 20th 2015, medication change sticker was placed to Resident # 5 prescription label by the Director of Nursing or designee.</p> <p>2) Resident prescription labels were assessed by Director of Nursing or designee on or before February 20th 2015 to ensure medication prescription legend was not altered. Prescription legends noted with changes were updated at the time of findings.</p> <p>3) Licensed nursing were re-educated by the Director of Nursing or designee on or before February 20th 2015 regarding procedure for medication orders changing and pharmacy labeling changes.</p>	

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C 833	Continued From page 4 LN stated, "One of the nurses." On 12/17/14 at 6:10 p.m., the Administrator, DON, and Nurse Consultant were informed of the alteration. The facility did not provide any other information regarding the issue.	C 833	<p>4) Beginning the week of February 23rd, 2015, Director of Nursing or designee will review 5 medication changes per week for 4 weeks, then monthly for 2 months to ensure original medication prescription legend is not altered. Audit results will be reported to the Performance Improvement Committee for a minimum of 3 months or until compliance sustained.</p> <p>5) The Director of Nursing is responsible for monitoring and compliance.</p> <p>Compliance Date: 02/20/2015</p> <p>C835</p> <p>Please refer to POC for F176</p> <p>C851</p> <p>Please refer to POC for F431</p>	
C 835	02.201,02,I Meds In Possession of Resident Limitations i. No medication shall be in the possession of the patient/resident unless specifically ordered by the physician on the patient's/resident's medical record, and in no case shall exceed two (2) units of dosage. All such medications shall be individually packaged by the pharmacist in units of dose, labeled with the patient's/resident's name, unit of dose, and date of distribution. The charge nurse shall maintain an inventory of these drugs on the patient's/resident's medical record. This Rule is not met as evidenced by: Refer to F176 as it related to self-administration of medications.	C 835		
C 851	02.201,03,e Storage of Schedule II Drugs e. Schedule II drugs shall be stored in a separate, locked section of the medication storage area or cabinet. (Alternate allowed under Unit Dose Pharmacy and emergency drug kit provisions.) This Rule is not met as evidenced by:	C 851		

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C 851	Continued From page 5 Refer to F 431 as it related to storage of a fentanyl patch, a controlled medication.	C 851		
C 882	02.203,02,a Resident Identification Requirements a. Patient's/resident's name and date of admission; previous address; home telephone; sex; date of birth; place of birth; racial group; marital status; religious preference; usual occupation; Social Security number; branch and dates of military service (if applicable); name, address and telephone number of nearest relative or responsible person or agency; place admitted from; attending physician; date and time of admission; and date and time of discharge. Final diagnosis or cause of death (when applicable), condition on discharge, and disposition, signed by the attending physician, shall be part of the medical record. This Rule is not met as evidenced by: Based on staff interview and record review, it was determined the facility failed to provide the cause of death, or final diagnosis, signed by the attending physician for 1 of 1 sample residents (#11) during closed record review. Findings include. Resident #11 was admitted to the facility on 6/28/12 with diagnoses including basal cell carcinoma. The resident expired in the facility on 10/5/14. Review of the resident's closed medical record revealed it did not contain the cause of death or a	C 882	C882 1) On or before February 20th 2015 the Director of Nursing or designee received a cause of death signed by the physician for resident # 11 2) Residents that were deceased in the last 3 months were reviewed by the Director of Nursing or designee for a cause of death signed by the physician. Documentation was received and placed in medical record on or February 20th 2015. 3) Medical Records Manager was re-educated by the Director of Nursing or designee on or before February 20th 2015 regarding procedure for receiving cause of death or final diagnosis signed by the physician prior to closing record. 4) Beginning the week of February 23 rd , 2015, Director of Nursing or designee will review 3 deaths in facility per week for 4 weeks, and then monthly for 2 months to ensure cause of death or final diagnosis is in place and signed by physician. Audit results will be reported to the Performance Improvement Committee for a minimum of 3	

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C 882	<p>Continued From page 6</p> <p>final diagnosis.</p> <p>On 12/17/14 at 4:15 p.m., the Nurse Practice Educator (NPE) was interviewed. The NPE indicated she assisted in the medical records department. When asked to provide the cause of death or final diagnosis signed by the resident's physician, the NPE responded, "The facility does not get a copy of the death certificate or notification of the cause of death."</p> <p>On 12/17/14 at 6:10 p.m., the Administrator, DON, and Nurse Consultant were informed of the issue. The facility did not provide any other information regarding the issue.</p>	C 882	<p>months or until compliance sustained.</p> <p>5) The Director of Nursing is responsible for monitoring and compliance.</p> <p>Compliance Date: 02/20/2015</p>	