



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

October 19, 2016

Trevor Cardon, Administrator
Madison Carriage Cove Short Stay Rehabilitation
410 West 1st North
Rexburg, ID 83440-1406

Provider #: 135140

Dear Mr. Cardon:

On **October 5, 2016**, a survey was conducted at Madison Carriage Cove Short Stay Rehabilitation by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567 listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct." **Please provide ONLY ONE completion date for each federal and state tag (if applicable) in column (X5) Completion Date** to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.

Trevor Cardon, Administrator
October 19, 2016
Page 2

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **October 29, 2016**. Failure to submit an acceptable PoC by **October 29, 2016**, may result in the imposition of penalties by **November 11, 2016**.

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

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

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

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

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

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **November 9, 2016 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **January 3, 2017**. A change in the seriousness of the deficiencies on **November 19, 2016**, may result in a change in the remedy.

Trevor Cardon, Administrator
October 19, 2016
Page 3

The remedy, which will be recommended if substantial compliance has not been achieved by **November 9, 2016** includes the following:

Denial of payment for new admissions effective **January 3, 2017**. [42 CFR §488.417(a)]

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

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **April 3, 2017**, if substantial compliance is not achieved by that time.

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

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

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **January 3, 2017** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

<http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/NursingFa>

Trevor Cardon, Administrator
October 19, 2016
Page 4

[ilities/tabid/434/Default.aspx](#)

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

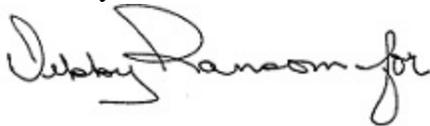
- BFS Letters (06/30/11)

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

This request must be received by **October 29, 2016**. If your request for informal dispute resolution is received after **October 29, 2016**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, comments or concerns, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2.

Sincerely,

A handwritten signature in black ink that reads "David Scott for". The signature is written in a cursive style.

David Scott, RN, Supervisor
Long Term Care

ds/pt
Enclosures

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

PRINTED: 11/09/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135140	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/05/2016
NAME OF PROVIDER OR SUPPLIER MADISON CARRIAGE COVE SHORT STAY REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 410 WEST 1ST NORTH REXBURG, ID 83440		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS The following deficiencies were cited during the federal recertification survey from October 3 to October 6, 2016. The surveyors conducting the survey were: Amy Barkley, RN, BSN, Team Coordinator Ophelia McDaniel, RN am = morning CNA = Certified Nursing Assistant DNS = Director of Nursing Services mg = milligram ml = milliliter RN = Registered Nurse	F 000			
F 156 SS=E	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for	F 156		11/4/16	

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

TITLE

(X6) DATE

Electronically Signed

10/28/2016

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

PRINTED: 11/09/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135140	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/05/2016
NAME OF PROVIDER OR SUPPLIER MADISON CARRIAGE COVE SHORT STAY REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 410 WEST 1ST NORTH 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 156	<p>Continued From page 1</p> <p>which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State</p>	F 156			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135140	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/05/2016
NAME OF PROVIDER OR SUPPLIER MADISON CARRIAGE COVE SHORT STAY REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 410 WEST 1ST NORTH 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 156	<p>Continued From page 2</p> <p>ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</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 residents were provided with an Advanced Beneficiary Notice at the initiation, reduction, or termination of their Medicare Part A benefits. This deficient practice was true for 5 of 5 residents (#8, #11, #12, #13, & #14) reviewed for Advanced Beneficiary Notice. This failure created the potential for residents to experience financial and psychological distress when residents were not informed regarding their potential liability for payment. Findings include:</p>	F 156	<p>What corrective action(s) will be accomplished for those residents found to be affected by the deficient practice?</p> <p>Resident #8, #11, #12, #13, & #14 have all been discharged.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken?</p> <p>All current and future residents have the</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135140	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/05/2016
NAME OF PROVIDER OR SUPPLIER MADISON CARRIAGE COVE SHORT STAY REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 410 WEST 1ST NORTH 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 156	<p>Continued From page 3</p> <p>The records of Residents #8, #11, #12, #13, & #14 were reviewed. A completed Advanced Beneficiary Notice (ABN) was not found in the 5 records. The purpose of the ABN was to notify and explain to the resident, and/or legal representative, in writing the reason specific services may not be covered after the coverage end date, and the beneficiary's potential liability for payment for non-covered services. In addition, Resident #8's record did not include a written notice on Medicare Non-Coverage had been issued to him.</p> <p>On 10/6/16 at 9:50 am, the Administrator stated he was not familiar with the ABN, however, he verbally notified and provided each resident with a written Notice of Medicare Non-Coverage two days prior to the date her/his coverage terminated. He stated he did not document in the residents' records the reason(s) the specific services may not be covered after the coverage end date and the beneficiary's potential liability for payment for non-covered services.</p>	F 156	<p>potential to be affected by the deficient practice.</p> <p>The Social Services and/or designee has been trained on the purpose of the ABN (Advanced Beneficiary Notice) and the proper process in explaining to the resident, and/or legal representative, in writing the reason specific services may not be covered after the coverage end date, and the beneficiary's potential liability for payment for non-covered services.</p> <p>What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?</p> <p>The Discharge Planning Policy and Procedure has been updated to reflect the purpose of the ABN (Advanced Beneficiary Notice) and the process of providing the ABN as well as the NONMC (Notice of Medicare Non-Coverage) to the patient verbally and in written form 2 days prior to discharge.</p> <p>During the business week daily department head meeting, each patient is reviewed and discharge plan discussed to identify the need to issue the ABN and NONMC.</p> <p>Medical Records and/or designee will complete weekly audits for the first 4 weeks to ensure the ABN (Advanced Beneficiary Notice) is being provided to</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135140	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/05/2016
NAME OF PROVIDER OR SUPPLIER MADISON CARRIAGE COVE SHORT STAY REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 410 WEST 1ST NORTH 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 156	Continued From page 4	F 156	<p>the patients per the updated policy. The audit results will be reviewed and if appropriate QA Committee will change the audits to bimonthly for 2 months. Those audit results will be reviewed and if appropriate QA Committee will change the audits to monthly for 3 months. Those audit results will be reviewed and if appropriate QA Committee will change the audits to quarterly for 6 months. At the end of 12 months, the QA committee will determine the frequency of the audits based upon findings.</p> <p>How will the corrective action(s) be monitored to ensure the deficient practice will not recur?</p> <p>The Medical Records or designee will share the audits with the Quality Improvement Committee at least quarterly to ensure the policy is being followed and any negative findings will be addressed and corrected.</p>		
F 332 SS=D	<p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE</p> <p>The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to maintain a medication error rate less than 5 percent. This was true for 3 of 28 medications, an</p>	F 332	<p>What corrective action(s) will be accomplished for those residents found to be affected by the deficient practice?</p>	11/7/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135140	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/05/2016
NAME OF PROVIDER OR SUPPLIER MADISON CARRIAGE COVE SHORT STAY REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 410 WEST 1ST NORTH 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 332	<p>Continued From page 5</p> <p>error rate of 10.7%. This deficient practice affected 2 of 4 random residents (#9 & #10) observed during medication pass. This failure created the potential for less than optimal benefit when medications were not administered according to manufacturer's specifications and/or physician orders. Findings include:</p> <p>1. Resident # #10 was admitted to the facility with multiple diagnoses including benign prostatic Hyperplasia (BPH).</p> <p>Resident #10's Dutasteride orders included:</p> <ul style="list-style-type: none"> - Admission orders, dated 9/21/16 documented, Dutasteride 0.5 mg take one capsule by mouth daily before breakfast. - Physician orders for September/October 2016 documented, Dutasteride 0.5 mg give one capsule by mouth in the morning. - The pharmacy provided medication bubble pack documented, Dutasteride 0.5 mg take one capsule by mouth daily before breakfast. <p>On 10/4/16 at 8:40 am, RN #1 was observed to administer Dutasteride 0.5 mg to Resident #10, approximately 30 minutes after he finished his breakfast. When asked the reason the medication was not given prior to breakfast, RN #1 stated the Electronic Medication Record (EMAR) did not include the directions to administer the medication prior to breakfast. When asked if she had compared the EMAR with the label and directions on the bubble pack, she stated she had not. RN #1 reviewed the label and confirmed the medication should have been administered prior to breakfast.</p> <p>2. Resident #9 was admitted to the facility with</p>	F 332	<p>Resident #9 & #10 have been discharged. RN #1 has received training regarding medication administration.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken?</p> <p>All current and future residents have the potential to be affected by the deficient practice.</p> <p>An audit was completed comparing the current orders to the admission orders and the appropriate actions were taken per the audit results.</p> <p>What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?</p> <p>The Policy and Procedure related to Resident Centered Medication Pass Policy and Protocols was reviewed and updated.</p> <p>Education has been provided for the nursing staff related to the updated Medication Pass policy. The importance of following the 5 rights during medication pass was also reviewed with the nursing staff.</p> <p>DON or designee will perform a medication pass audit on each licensed nurse within 2 weeks. After those two</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135140	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/05/2016
NAME OF PROVIDER OR SUPPLIER MADISON CARRIAGE COVE SHORT STAY REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 410 WEST 1ST NORTH 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 332	<p>Continued From page 6</p> <p>multiple diagnoses, including gastro-esophageal reflux disease (GERD).</p> <p>Resident #9's Sucralfate orders included: - Admission orders, dated 8/1/16, and physician orders for August/September/October 2016 documented, Sucralfate 1gm/10ml suspension give 10 ml by mouth four times a day related to breakdown of esophageal anti-reflux device. The order did not include that the medication should be administered one hour before meals or two hours after meals and at bedtime per the manufacturer's specifications. - The paper EMAR, dated September 2016, documented, Sucralfate Suspension 1gm/10ml give 10 ml four times a day at 8:00 am, 12:00 pm, 4:00 pm, and 8:00 pm.</p> <p>The facility's posted meal times included: Breakfast at 8:00 am, lunch at 12:00 pm, and dinner at 5:30 pm.</p> <p>On 10/4/16 at 9:00 am, RN #1 was observed to administer Sucralfate 10 ml suspension to Resident #9, approximately 1 hour after she had finished her breakfast.</p> <p>On 10/4/16 at 12:39 pm, RN #1 was observed to administer Sucralfate 10 ml suspension to Resident #9, approximately 30 minutes after she had completed lunch.</p> <p>On 10/6/16 at 12:30 pm, the DNS and Unit Manager stated the facility had received different directions from the pharmacy and nurse consultant related to different options for administration times. She acknowledged the above medications had not been administered</p>	F 332	<p>weeks, the DON or designee will perform a random medication audit a week for the first 4 weeks to ensure the updated policy and manufacturing recommendations are being followed. The audit results will be reviewed and if appropriate the QA committee will change the audits to bimonthly for 2 months. Those audit results will be reviewed and if appropriate QA committee will change the audits to monthly for 3 months. Those audit results will be reviewed and if appropriate QA committee will change the audits to quarterly for 6 months. At the end of 12 months, the QA committee will determine the frequency of the audits based upon findings.</p> <p>How will the corrective action(s) be monitored to ensure the deficient practice will not recur?</p> <p>After an admission, an audit will be performed to compare admitting orders to the orders entered into the EMAR within 12 hours from admission.</p> <p>We have established a quality assurance and performance improvement (QAPI) measure / goal for medication errors on a monthly basis. A full evaluation of all the systems and processes relating to medications will occur should we fail to meet our goal. The DON or designee will be responsible to report these findings to the QA Committee at least quarterly.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135140	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/05/2016
NAME OF PROVIDER OR SUPPLIER MADISON CARRIAGE COVE SHORT STAY REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 410 WEST 1ST NORTH 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 332	Continued From page 7 consistent with the manufacturer's specifications or physician orders.	F 332			
F 518 SS=F	<p>483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS</p> <p>The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review it was determined the facility failed to ensure staff were knowledgeable about what to do in the event of a fire and partial evacuation at the facility. This was true for 3 of 6 (RN #2, CNA #1, and Dietary Manager) staff interviewed for emergency preparedness. This deficient practice created the potential for harm should a fire occur and threatened the safety of the residents. Findings include:</p> <p>The facility's fire response procedure and partial evacuation procedure included:</p> <ol style="list-style-type: none"> 1. Look at the alarm indicator at the north nurses' station or the main entrance. 2. Evacuate the resident(s) who are in immediate danger of the fire. 3. Pull closest fire alarm and alert all persons in the facility, "Code Red." 4. Call 911 and direct the Administrator be notified. 5. Use fire extinguisher and attempt to extinguish if this can be done safety. 	F 518	<p>What corrective action(s) will be accomplished for those residents found to be affected by the deficient practice?</p> <p>Specific residents were not identified as being affected by the deficient practice.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken?</p> <p>All current and future residents and staff have the potential to be affected by the deficient practice.</p> <p>What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?</p> <p>The policy and procedure for the fire response procedure and partial evacuation procedure has been reviewed</p>	11/3/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135140	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/05/2016
NAME OF PROVIDER OR SUPPLIER MADISON CARRIAGE COVE SHORT STAY REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 410 WEST 1ST NORTH 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 518	<p>Continued From page 8</p> <p>6. Close all doors and windows as able in the fire area to minimize oxygen supply to the fire.</p> <p>7. Evacuation of immediate area - See instructions entitled, "Evacuation of Residents Partial or, "Evacuation of Facility, Total." In the event of an evacuation residents should be removed from the facility in this order: Ambulatory, wheelchair bound, and bed ridden. Leave doors open as you evacuate each room so that other personal will not waste time rechecking rooms.</p> <p>On 10/6/15 at 9:00 am, CNA #1 stated she was not sure what the process was to indicate residents had been evacuated from their rooms and she needed to find out. When asked what order she would remove residents from the fire area and or facility, she stated she would remove the residents that required the most help first, bed ridden residents, residents in wheelchairs, and ambulatory.</p> <p>On 10/6/16 at 9:10 am, the Dietary Manager (DM) stated he would check the alarm indicator at the front door and then notify all staff over their radios of the location of the fire. When asked what Code Red meant when announced over the intercom he stated, "I'm not sure what Code Red means and I should." When asked what the process was to indicate residents had been evacuated from their rooms, the DM stated the door is pulled shut and is marked with an "X" to indicate the room is vacated. He stated if a resident is in his/her room and the fire is not in area of the room the resident should remain in his/her room and the door should be shut. He stated he was, "not exactly sure" in what order residents should be evacuated, "but if I had to</p>	F 518	<p>and revised.</p> <p>Education has been provided for staff related to fire response procedure and partial evacuation procedure.</p> <p>Education will be provided during the general orientation process for both of these policies as well as other aspects of the facility emergency plan.</p> <p>There will be monthly training regarding fire response procedure and partial evacuation procedure for staff for the first 3 months. After the first 3 months, training will be provided quarterly on these procedures. At the end of a 12 months, the Quality Assurance committee will decide the frequency of the additional training being provided (outside of general orientation and no less than twice per year).</p> <p>During the fire drills performed on a quarterly basis (each shift will be part of a fire drill at least quarterly), the Maintenance Director or designee will review the updated policy and ask questions to ensure the policy is being followed and staff is aware of the policy.</p> <p>How will the corrective action(s) be monitored to ensure the deficient practice will not recur?</p> <p>The additional training findings as well as the fire drill outcomes will be reviewed in the Quality Assurance Committee Meeting at least quarterly.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135140	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/05/2016
NAME OF PROVIDER OR SUPPLIER MADISON CARRIAGE COVE SHORT STAY REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 410 WEST 1ST NORTH 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 518	<p>Continued From page 9 say it would be ambulatory, wheelchair bound, and bed ridden."</p> <p>On 10/6/16 at 9:20 am, RN #2 stated a CNA checks the alarm indicator box at the nurses' station to determine the location of the fire and takes steps to extinguish the fire. The Nurse on the floor checks all of the resident rooms, closes the doors, and places red tape under the door handle to indicate the resident is in his/her room. She stated she did not know what the procedure was to indicate a room had been evacuated.</p> <p>The facility's monthly fire drill forms, from 3/30/16 to 9/30/16 were reviewed and the person conducting the drills documented the following: * On 6/30/16, "I made sure all nursing staff on shift knew how to appropriately respond to a fire alarm." * On 7/29/16, "Some staff were slow to figure out where the alarm was pulled." * On 9/30/16, "Some staff struggled to figure out where the alarm was pulled. Staff was instructed on the directions and how to better locate where the fire would be."</p> <p>On 10/6/16, at 1:00 pm, the Administrator stated a refresher would be provided to all staff related to the procedures during an fire drill and partial evacuation of the facility.</p>	F 518			