



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

February 15, 2017

Mark Teckmeyer, Administrator
Bingham Memorial Skilled Nursing & Rehabilitation
98 Poplar Street
Blackfoot, ID 83221-1758

Provider #: 135007

Dear Mr. Teckmeyer:

On **January 19, 2017**, a survey was conducted at Bingham Memorial Skilled Nursing & 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 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. 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.) **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.

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 **February 27, 2017**. Failure to submit an acceptable PoC by **February 27, 2017**, may result in the imposition of civil monetary penalties by **March 20, 2017**.

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*.

We are recommending that Centers for Medicare & Medicaid Services (CMS) Region X impose the following remedy(ies):

- Civil money penalty
- DPNA made on or after **April 19, 2017**

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **July 19, 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.

Mark Teckmeyer, Administrator
February 15, 2017
Page 3 of 4

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.

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 **February 27, 2017**. If your request for informal dispute resolution is received after **February 27, 2017**, 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,



Nina Sanderson, LSW, Supervisor
Long Term Care

DR/lj

Mark Teckmeyer, Administrator
February 15, 2017
Page 4 of 4

Enclosures

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

PRINTED: 03/03/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/19/2017
NAME OF PROVIDER OR SUPPLIER BINGHAM MEMORIAL SKILLED NURSING & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 98 POPLAR STREET BLACKFOOT, ID 83221		
(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 complaint investigation survey conducted at the facility from January 18, 2017 through January 19, 2017. The surveyors conducting the survey were: Brad Perry, BSW, LSW, Team Coordinator Linda Kelly, RN Marci Clare, RN Survey Definitions: ADL = Activities of Daily Living ADON = Assistant Director of Nursing BFS = Bureau of Facility Standards BID = Two times a day CNA = Certified Nursing Assistant CVA = Cerebrovascular Accident D/C(d) = Discontinue/discontinued DON = Director of Nursing ER = Extended Release Fax = Facsimile IDT = Interdisciplinary Team JPOC = Joint Plan of Care LN(s) = Licensed Nurse(s) LPN = Licensed Practical Nurse MAR = Medication Administration Record mcg/hr = micrograms per hour mg/mL = milligrams per milliLiter PO = By mouth prn = As needed RN = Registered Nurse Q = Every	F 000			
F 225 SS=D	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS	F 225		3/24/17	

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

TITLE

(X6) DATE

Electronically Signed

02/27/2017

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 225	Continued From page 1 (a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not	F 225			

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F 225	<p>Continued From page 2</p> <p>involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.</p> <p>(2) Have evidence that all alleged violations are thoroughly investigated.</p> <p>(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.</p> <p>(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interviews, closed record review, and review of the facility's policies and investigations, it was determined the facility failed to ensure an allegation that staff did not move or change a resident for several hours (neglect) was thoroughly investigated. This was true for 1 of 6 sample residents (#5). The lack of a thorough investigation created the potential for neglect to go undetected and lack of care to continue. Additionally, the facility failed to ensure its abuse policy addressed all requirements for reporting allegations to State Survey Agency. This had the potential to jeopardize the safety of residents. Findings include:</p>	F 225	<p>*CORRECTIVE ACTIONS FOR RESIDENT SPECIFIC:</p> <p>¿ Resident # 5 was affected by this deficient practice.</p> <p>¿ Concern form and subsequent investigation occurred timely. SNRC management team set-up a family meeting with spouse of patient, father of patient and a BMH Espa¿ola interpreter. What transpired from the meeting was communication from family members not to move patient for a particular time in which the concern occurred. We were</p>		

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F 225	Continued From page 3 Resident #5 was admitted to the facility on 10/20/16, with multiple diagnoses including right-sided weakness related to a CVA and terminal metastatic cancer for which hospice care was in place. Resident #5 died in the facility on 10/25/16. A 10/23/16 facility concern form documented Resident #5, "was not moved or changed since noc [night]" and a nurse was the only staff seen in the resident's room during the night. The date/time of the occurrence was noted as "10/22/16 up to 10/23/16" and that night shift staff on 10/22/16 and day shift staff on 10/23/16 were involved. The concern form documented Resident #5 was "found soiled" at the time of the complaint, the resident was changed and bathed with hospice staff assistance, and the bed was "changed & sanitized by housekeeping." The concern form also noted that an order to change a pain medication was not processed and morphine sulfate every hour "was rendered" after that. The concern form documented the day and night shift staff were "informed" of the plan of care for frequent checks, repositioning, and medicating to keep the resident comfortable unless it was refused. Statements by two "dayshift" CNAs were included with the 10/23/16 concern form; however, there were no statements by the night or day shift LNs, the night shift CNA, or the involved hospice staff. A Resident Progress Note, dated 10/23/16 at 7:21 pm, documented, "...was told in report this morning that patient's family likes her to only be on one side and did not like her to be repositioned. Plan of care changed for patient	F 225	able to explain to the family that we needed to provide cares to meet the patients' needs. The family agreed to this course of action. The outcome of the meeting was that the husband and father agreed to our course of action. ¿ A meeting with Hospice and the SNRC management team transpired to go over this case and forge a plan moving forward to have a concise POC that both parties agree to. We met with the Hospice Administrator and Hospice Nurse. There were elements on both side of the table that were discussed and agreed upon to have better current and future coordinated POC's. ¿ Night staff on 10/22/16 will be interviewed and statements will be obtained as it relates to the 10/23/16 concern. ¿ Day staff License Nurse on 10/23/16 will be interviewed and statements will be obtained as it relates to the 10/23/16 concern. ¿ LN#1 was educated regarding the facility grievance procedure. *CORRECTIVE ACTION FOR POTENTIAL RESIDENTS THAT MAY BE AFFECTED BY THIS DEFICIENT PRACTICE : ¿ All residents whether on hospice or not has the potential to be affected by this deficient practice. -The current hospice resident will be visited by LSW to ensure that her current needs are met and any abuse or neglect reported will be dealt with immediately.		

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F 225	<p>Continued From page 4</p> <p>comfort for reposition every 2 hours and as needed...patient showed high levels of pain and received medication..."</p> <p>An 11/6/16 "Response to Concern" of 10/23/16 documented an IDT meeting, involving several facility staff, a hospice nurse, Resident #5's spouse and an interpreter, was held 10/24/16 at 11:00 am and the "family gave directives that they do not want staff to reposition [Resident #5] and it was ok for staff to provide personal hygiene when needed."</p> <p>On 1/19/17 at 11:05 am, LPN #1 said she was the supervising nurse on duty when the 10/23/16 concerns were made. LPN #1 said she talked to the night shift nurse about the issue but she did not remember if the nurse wrote a statement. The Administrator was present and said he thought a thorough investigation was conducted.</p> <p>On 1/19/17 at 12:30 am, LPN #1 said the 10/23/16 concerns were made "sometime in the afternoon" and she notified the Administrator "immediately" and implemented corrective measures right away. LPN #1 said she instructed the day shift nurse to write a "good note" and she talked to the night shift nurse at some point. LPN #1 said she did not write the interviews down or request/obtain statements from either of the nurses, the night shift CNA, or the hospice staff involved.</p> <p>On 1/19/17 at 2:38 pm, RN #2 said he cared for Resident #5 for 2 nights in a row including from 6:00 pm on 10/22/16 to 6:00 am on 10/23/16, then he was off work for several days. RN #2 said the family did not want Resident #5 moved</p>	F 225	<p>*MEASURES(FACILITY SYSTEMS) THAT WILL BE PUT IN PLACE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR:</p> <p>-In-service will be held on the following topics:</p> <ol style="list-style-type: none"> 1.F Tag 225 2. The updated facility Abuse, Neglect, and Misappropriation of Property Policy #1225 3.Simplified facility Grievance procedure <p>-The facility Abuse, Neglect, and Misappropriation of Property Policy #1225 will be updated to include the regulatory requirement that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury; or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency)..."</p> <p>-The NHA during the daily stand up will inquire for any presence of any grievance received by any member of the Interdisciplinary team, and will be added in the daily agenda .If a grievance is present, it will be audited to rule out abuse and neglect has occurred. This is to ensure that a thorough investigation is conducted as mandated by F tag 225.</p>		

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F 225	<p>Continued From page 5</p> <p>when she was sleeping and they would "wave at me" or "come get me" with concerns, usually related to pain. RN #2 said he "heard something" about the 10/23/16 allegations after his days off but he "never" gave a statement to anyone about it.</p> <p>On 1/19/17 at 3:07 pm, CNA #1 said she worked the night shift. The CNA vaguely recalled caring for Resident #5 but did remember that the nurse "preferred we didn't bug" the resident too often.</p> <p>On 1/19/17 at 3:12 pm, LPN #2 said she worked with Resident #5 one day and the family was a "little upset that we didn't reposition" her. LPN #2 said the family wanted Resident #5 only on 1 side and the family would say she was comfortable "so we wouldn't turn her."</p> <p>The facility failed to conduct a thorough investigation of the allegations documented on the 10/23/16 facility concern form, which described potential neglect of Resident #5.</p> <p>The facility's "Abuse, Neglect and Misappropriation of Property" policy, effective 10/25/13, documented, "...leadership will conduct an internal investigation...and will provide notification and the release of information to the proper authorities...Identification...Physical Neglect...Inadequate provision of care...alleged allegations...is [sic] reported immediately to the supervising nurse on duty...the supervising nurse should call Administrator immediately. Administrator will then lead and work with other personnel to complete the investigation...Administrator will report allegations, investigation findings and corrective</p>	F 225	<p>-Refer to plan of correction for F tag 281 as it pertains to medication issues.</p> <p>*MONITORING A.WHO: NHA / Designee</p> <p>B.FREQUENCY: - will inquire daily for presence of a grievance and audit if grievance is present .Any issue noted will be immediately addressed.</p> <p>C.START DATE: -February 27,2017</p> <p>*DATES WHEN CORRECTIVE ACTION IS COMPLETED: - March 24 ,2017</p>		

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F 225	Continued From page 6 measures taken to resident, family and other agencies as required...The Bureau of Facility Standards (BFS) will be notified of the investigation results within 5 days of occurrence." The policy did not include the regulatory requirement that, "...all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency)..."	F 225			
F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure licensed nurses adhered to professional standards of practice related to medication management and administration. This was true for 1 of 6 residents (#5) reviewed for use of controlled medications. The deficient practice	F 281	*CORRECTIVE ACTIONS FOR RESIDENT SPECIFIC: ¿ Resident # 5 was affected by this deficient practice. - LN #4 was counseled and educated regarding medication administration with emphasis on the importance of	3/24/17	

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F 281	<p>Continued From page 7</p> <p>created the potential for diversion of narcotic medications when the administration of Resident #5's controlled medications were not consistently documented and/or tracked, and for more than minimal harm when controlled medications were administered at a dose and/or time that differed from the physician's order or medications were omitted without explanation. Findings include:</p> <p>According to Potter, Perry & Ostendorf (2014), Clinical Nursing Skills & Techniques, 8th ed., safe medication administration is obtained in accordance with the six rights of medication administration: right medication; right dose; right patient; right route; right time; and right documentation. Record medications immediately after administration. If a patient refuses a medication, document that it was not given, the reason for refusal, and when you notified the health care provider. Guidelines for Safe Narcotic Administration and Control include: "An inventory record is used each time a narcotic is dispensed...and provide an accurate ongoing account of the narcotics used, wasted, and remaining..." These standards were not followed.</p> <p>Resident #5 was admitted to the facility on 10/20/16 with multiple diagnoses, including right-sided weakness related to a CVA and terminal metastatic cancer with hospice care in place. Resident #5 died in the facility on 10/25/16.</p> <p>Resident #5's 10/20/16 hospice orders included morphine ER 30 mg po BID and morphine sulfate 20 mg/ml solution 0.5-1 ml po every 1-2 hours prn for pain.</p>	F 281	<p>documenting when medications are being held for a resident and where it is documented.</p> <p>-L.N #3 was counseled and educated regarding pain management with emphasis on the nonverbal cues of pain and communicating with the Doctor or hospice nurse regarding modifying the resident's plan of care according on her assessment of the resident's current needs.</p> <p>¿ *CORRECTIVE ACTION FOR POTENTIAL RESIDENTS THAT MAY BE AFFECTED BY THIS DEFICIENT PRACTICE :</p> <p>-All residents who experience pain whether they are hospice or non-hospice residents has the potential of being affected by the deficient practice. All residents will have new pain assessments and basing from their response, their plan of care will be evaluated and updated to reflect their current status. The attending Doctor will be called for any issues discovered. Residents on current pain medications will be reviewed to ensure that they are receiving the correct doses of medications ordered by their Doctor.</p> <p>*MEASURES(FACILITY SYSTEMS) THAT WILL BE PUT IN PLACE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR:</p> <p>-The License nurses will be in serviced on the following :</p> <p>a. Pain management (emphasis on the</p>		

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F 281	<p>Continued From page 8</p> <p>Resident #5's October 2015 Medication Flowsheets documented the morphine ER was administered at 3:00 am and 3:00 pm on 10/21/16, circled as held both times on 10/22/16, then discontinued. The flowsheet also contained blanks in all of the spaces for documentation of prn morphine solution 20 mg/mL 0.5-1 mL po prn every 1-2 hours, which indicated the medication was not administered at all.</p> <p>The reason Resident #5's morphine ER was held was not documented in Resident Progress Notes, dated 10/21/16 at 5:30 am to 10/25/16. In addition, progress notes for 10/21/16 and 10/23/16 documented the prn liquid morphine was administered to Resident #5 several times.</p> <p>On 1/19/17 at 2:38 pm, LN #4 said he administered the prn Roxanol to Resident #5 several times on 10/21/16 and 10/22/16 and that he held the morphine ER because the resident was unable to swallow. The LN did not recall if he documented why he held the morphine ER and said he documented the prn morphine administrations on a Controlled Substance Administration Record but not on the Medications Flowsheet.</p> <p>A telephone order, dated 10/22/16 at 10:00 am, ordered morphine (Roxanol) 20 mg/mL 1 mL po every hour. This medication order was not included in Resident #5's October 2015 Medication Flowsheets. However, morphine 20 mg/5 mL (or 4 mg/mL) 0.5-1 mL po every hour was noted on the Medication Flowsheet and documented as administered hourly beginning at 7:30 pm on 10/23/16 through 2:20 am on 10/25/16, except when it was held 5 times,</p>	F 281	<p>signs and symptoms of nonverbal pain, effectiveness of current pain regimen, documenting pain status)</p> <p>b. The Six Rights of Medication Administration (emphasis on correct dosing and documenting when holding medications)</p> <p>c. The Bingham Memorial Skilled Nursing and Rehabilitation Center Controlled Substance Accountability and Distribution Policy #651 (emphasis on the process of documenting /tracking controlled medications outside of an automated drug Cabinet) .</p> <p>d. The importance of Following Doctor's orders and communicating with the provider to update plan of care if needed.</p> <p>-The facility will audit the following :</p> <ol style="list-style-type: none"> 1. Any prn pain medications administered daily to ensure that they are documented in the MAR and the controlled administration record for medications not obtained from the automated drug cabinet. 2. Any held medications are documented appropriately and the rationale for holding the medication. 3. Medication Administration Record for any blanks and the rationale why it is not documented. <p>*MONITORING A.WHO: -The DNS/Designee B.FREQUENCY: - will audit daily for 1month, then 3x/week</p>		

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F 281	Continued From page 9 without explanation, and 3 spaces for administration were blank on 10/24/16. A Resident Progress Note, dated 10/23/16 at 7:21 pm, documented Resident #5 was medicated for pain "every hour this shift after 1330 [1:30 pm]." Documentation of hourly administrations of morphine did not start until 7:30 pm on 10/23/16. In addition, on 1/19/17 at 5:10 pm, LN #3 said she was "not comfortable" administering morphine hourly when Resident #5 was "already sedated." LN #3 said she did not notify the physician of this and she would "pass off" to another nurse. On 1/19/17, the DON provided a 10/22/16 Controlled Substance Administration Record which documented morphine 20 mg/mL po every hour was administered beginning at 3:30 am on 10/24/16, though it was not always documented as hourly as ordered. The facility did not provide any other Controlled Substance Administration Records for morphine medications.	F 281	for 1 month, weekly x 1 month for a period of 12 weeks .Any issue noted will be immediately addressed. The QA committee will review any issues uncovered by the weekly audits and after the initial 12 weeks make a determination related to changing the frequency of those audits. C.START DATE: - March 6,2017 * DATES WHEN CORRECTIVE ACTION IS COMPLETED: - March 24,2017		
F 309 SS=G	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 (k) Pain Management.	F 309		3/24/17	

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F 309	<p>Continued From page 10</p> <p>The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.</p> <p>(I) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff interview, it was determined the facility failed to ensure orders to increase pain medications were implemented timely and that a different concentration and dose of pain medication was not administered without an order. This was true for 1 of 6 sample residents (#5) and resulted in harm when Resident #5 experienced increased pain when changes to pain medications were delayed or not implemented at all and a different concentration and dose of morphine solution than ordered was administered. Findings included:</p> <p>Resident #5 was admitted to the facility on 10/20/16, with multiple diagnoses including right-sided weakness related to a CVA and terminal metastatic cancer with hospice care in place. Resident #5 died in the facility on 10/25/16.</p> <p>Resident #5's 10/20/16 Discharge Medication Reconciliation Order Report included continuation of a fentanyl 25 mcg/hr patch every</p>	F 309	<p>*CORRECTIVE ACTIONS FOR RESIDENT SPECIFIC:</p> <ul style="list-style-type: none"> - Resident # 5 was affected by this deficient practice. -L.N #4 was counseled and educated regarding the importance of documenting administered controlled medications in the MAR. -L.N #3 was counseled and educated regarding the importance of documenting administered controlled medications in the MAR and nonverbal signs and symptoms of pain. -LN #2 was counseled and educated regarding the nonverbal signs and symptoms of pain and the importance of following MD order. <p>*CORRECTIVE ACTION FOR POTENTIAL RESIDENTS THAT MAY BE AFFECTED BY THIS DEFICIENT PRACTICE :</p>		

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F 309	<p>Continued From page 11</p> <p>72 hours and the 10/20/16 hospice orders included morphine ER 30 mg po BID and morphine sulfate 20 mg/ml solution 0.5-1 ml po every 1-2 hours prn pain.</p> <p>Resident #5's 10/20/16 facility pain assessment documented crushing, sharp, shooting and stabbing pain almost constantly at "9" on a scale of 0-10.</p> <p>A telephone order from the hospice physician on 10/22/16 at 10:00 am discontinued the morphine 30 mg ER and ordered Roxanol [short-acting, immediate release morphine solution] 20 mg/mL 1 mL po every hour. The order was noted as "received" and "performed" by a hospice nurse.</p> <p>Two other telephone orders from the hospice physician, both dated 10/23/16 at 1:00 pm, discontinued the fentanyl 25 mcg/hr patch and increased it to fentanyl 100 mcg/hr every 72 hours. These orders were also noted as "received" and "performed" by the same hospice nurse.</p> <p>Resident #5's Medication Flowsheets documented the following:</p> <p>* Pain "5" on 10/20/16 night shift and 10/21/16 day shift, "4" on 10/22/16 day shift, increased to "8" on 10/23/16 day shift and "0" on 10/24/16 day shift. The pain level was not documented on the night shift for 10/21/16, 10/22/16, 10/23/16 or 10/24/16.</p> <p>* Morphine ER 30 mg was administered on 10/21/16 at 3:00 am and 3:00 pm, held both times on 10/22/16 without explanation, then discontinued.</p>	F 309	<p>- All residents who experience pain whether they are hospice or non-hospice residents has the potential of being affected by the deficient practice. All residents will have new pain assessments and basing from their response, their plan of care will be evaluated and updated to reflect their current status. The attending Doctor will be called for any issues discovered. Residents on current pain medications will be reviewed to ensure that they are receiving the correct doses of medications ordered by their Doctor.</p> <p>- The hospice nurse for the current hospice resident in the facility was in serviced regarding the importance of coordinating care with specific focus on the following :</p> <ol style="list-style-type: none"> 1. Telephone, verbal or written Order processing 2. Resident current physical, mental and psychosocial status and current needs. <p>*MEASURES(FACILITY SYSTEMS) THAT WILL BE PUT IN PLACE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR:</p> <p>-The License Nurses will be educated on the following :</p> <ol style="list-style-type: none"> a. Pain management (emphasis on assessing pain status of the residents and documenting pain levels every shift, 		

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F 309	<p>Continued From page 12</p> <p>* PRN Morphine solution 20 mg/mL 0.5-1 mL prn every 1-2 hours" with blanks in all of the spaces for documentation.</p> <p>* Morphine solution 20 mg/5 mL (4 mg/mL) 0.5-1 mL hourly was administered hourly from 7:30 pm - 11:30 pm on 10/23/16; from 12:30 am - 4:30 am, 6:30 am, 11:30 am - 3:30 pm, then 7:30 pm - 11:30 pm on 10/24/16; and 12:30 am - 2:30 am on 10/25/16. Initials were circled at 5:30 am and 7:30 am - 10:30 am on 10/24/16 without explanation and the spaces for documentation were blank from 4:30 pm - 6:30 pm on 10/24/16. An order for this concentration and dose of morphine solution every hour was not found in the record.</p> <p>* Fentanyl 25 mcg/hr patch was administered on 10/20/16 at 8:00 pm.</p> <p>The Medication Flowsheets did not include the orders for morphine solution 20 mg/mL 1 mL every hour or fentanyl 100 mcg/hr patch every 72 hours, which were issued by the physician on 10/23/16 at 1:00 pm. In addition, orders for morphine solution 20 mg/5 mL (4 mg/mL) 0.5-1 ml every hour were not found in Resident #5's clinical record, nor were they provided by the facility.</p> <p>Resident Progress Notes, dated 10/21/16 at 5:30 am and 10/23/16 at 7:58 am, documented Resident #5 was medicated several times with liquid morphine during the night shift. However, the specific dose and times of administrations were not documented in Resident #5's clinical record, nor were they provided by the facility.</p> <p>A 10/22/16 Occurrence/Med Error Report documented, "Hospice agency...noticed roxanol</p>	F 309	<p>effectiveness of current pain regimen)</p> <p>b. documenting controlled substances in the MAR and the controlled narcotic Log</p> <p>c. The importance of coordinating care with the hospice staff.</p> <p>d. The Six Rights of Medication Administration (emphasis on correct dosing and documenting when holding medications).</p> <p>-The facility hospice policy as it pertains to order processing /coordination of care was updated.</p> <p>-The facility procedure for checking daily, new admission orders and processing of orders was updated.</p> <p>-The night license nurse duties will be updated to include in their daily 24 hour audit checks to physically check all the resident's hard charts with the goal of being able to intercept any unprocessed order for the day and be able to process them upon discovery.</p> <p>-The facility will audit daily and new admission orders of controlled medications to ensure that the orders are accurate(correct medication, dose, form ,administration time)orders are processed and documented as ordered by the Doctor</p> <p>*MONITORING</p> <p>A.WHO: -DNS/Designee</p> <p>B.FREQUENCY: - will audit daily for 1month , then 3x/week for 1 month ,weekly x 1 month for a period of 12 weeks .Any issue noted</p>		

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F 309	<p>Continued From page 13</p> <p>[sic] order was not processed, brought to charge nurse. Charge nurse processed order." The root cause was noted as, "Poor communication between hospice & [facility] staff."</p> <p>A 10/22/16 Controlled Substance Administration Record for morphine sulfate 20 mg/mL 1 mL po every hour documented the first dose was administered to Resident #5 on 10/24/16 at 3:30 am, but was not consistently administered every hour as ordered. The facility did not provide additional Controlled Substance Administration Records for morphine.</p> <p>A Resident Progress Note, dated 10/23/16 at 7:21 pm, documented, "...medicated every hour this shift after 1330 [1:30 pm]...patient showed high levels of pain..."</p> <p>Focused Observation Notes documented Resident #5's pain was "mild" on 10/22/16; Resident #5 was experiencing pain or hurting on 10/23/16; and on 10/24/16 at 8:26 am, "expresses experiencing pain or hurting: Unable to answer...Facial expressions (frowning, grimacing, wincing, wrinkled brow)...non-verbal sounds (sighing, moaning, groaning, crying, gasping).</p> <p>On 1/19/17 at 11:15 am, LN #1 said that on 10/22/16 in the afternoon a hospice nurse reported the order for morphine solution 20 mg/mL every hour had not been processed. LN #1 said the medication was started immediately. LN #1 said the hospice nurse who took the order had also signed the order as processed but did not communicate with facility staff about the change. LN #1 said the hospice nurse may have</p>	F 309	<p>will be immediately addressed. The QA committee will review any issues uncovered by the weekly audits and after the initial 12 weeks make a determination related to changing the frequency of those audits.</p> <p>C.START DATE: - March 6,2017</p> <p>*DATES WHEN CORRECTIVE ACTION IS COMPLETED: - March 24,2017</p>		

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F 309	Continued From page 14 put the order away without the facility staff seeing it. On 1/19/17 at 2:38 pm, LN #4 said he cared for Resident #5 two nights in a row and he administered prn Roxanol to her. The LN said he documented the administrations on a Controlled Substance Administration Record provided by the hospice but not on the facility's MAR. On 1/19/17 at 3:12 pm, LN #2 said she cared for Resident #5 "one day" and she administered pain medications "prn" until a hospice nurse said it was ordered every 1-2 hours. LN #2 said she gave the morphine every hour after that because Resident #5, "looked like she needed it." On 1/19/17 at 5:10 pm, RN #3 said she administered prn morphine to Resident #5 and documented it on controlled substance sheets but not on the facility's MAR. RN #3 said after the morphine was changed to hourly she did not always administer it hourly. LN #3 said she was "not comfortable" giving morphine when there were no signs of pain or restlessness. Resident #5 was harmed when her pain and discomfort increased when the facility failed to process and implement orders for morphine solution 20 mg/mL 1 mL (20 mg) every hour on 10/22/16 and failed to administer fentanyl 100 mcg/hr every 72 hours as ordered on 10/23/16. In addition, the facility administered different concentrations and doses of morphine solution than ordered.	F 309			
F 526 SS=G	483.70(o)(1)-(4) Hospice (o) Hospice services.	F 526		3/24/17	

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F 526	Continued From page 15 (1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. (2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide.	F 526			

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F 526	<p>Continued From page 16</p> <p>(B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter.</p> <p>(C) The services the LTC facility will continue to provide based on each resident's plan of care.</p> <p>(D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day.</p> <p>(E) A provision that the LTC facility immediately notifies the hospice about the following:</p> <p>(1) A significant change in the resident's physical, mental, social, or emotional status.</p> <p>(2) Clinical complications that suggest a need to alter the plan of care.</p> <p>(3) A need to transfer the resident from the facility for any condition.</p> <p>(4) The resident's death.</p> <p>(F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided.</p> <p>(G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care</p>	F 526			

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F 526	<p>Continued From page 17</p> <p>provided is appropriately based on the individual resident's needs.</p> <p>(H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions.</p> <p>(I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility.</p> <p>(J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.</p> <p>(K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.</p>	F 526			

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F 526	<p>Continued From page 18</p> <p>(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident.</p> <p>The designated interdisciplinary team member is responsible for the following:</p> <p>(i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services.</p> <p>(ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family.</p> <p>(iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians.</p> <p>(iv) Obtaining the following information from the hospice:</p>	F 526			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/19/2017
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F 526	<p>Continued From page 19</p> <p>(A) The most recent hospice plan of care specific to each patient.</p> <p>(B) Hospice election form.</p> <p>(C) Physician certification and recertification of the terminal illness specific to each patient.</p> <p>(D) Names and contact information for hospice personnel involved in hospice care of each patient.</p> <p>(E) Instructions on how to access the hospice's 24-hour on-call system.</p> <p>(F) Hospice medication information specific to each patient.</p> <p>(G) Hospice physician and attending physician (if any) orders specific to each patient.</p> <p>(v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents.</p> <p>(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.20. This REQUIREMENT is not met as evidenced by: Based on staff interviews and review of clinical</p>	F 526	*CORRECTIVE ACTIONS FOR		

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F 526	<p>Continued From page 20</p> <p>records, medication error reports and a facility/hospice agreement, it was determined the facility failed to: communicate and coordinate care with a hospice provider, develop a coordinated plan of care with hospice, and designate an IDT member to work with hospice for 1 of 2 residents (#5) reviewed for hospice services. The failures resulted in harm when Resident #5 experienced increased pain and discomfort in her final days of life after orders to increase pain medications were delayed or not implemented and an indwelling urinary catheter for comfort care order was not followed. Findings include:</p> <p>A 2015 facility/hospice provider agreement provided by the facility's Administrator on 1/19/17 documented, "...Facility and Hospice agree to cooperate...in carrying out each Patient's Joint Plan of Care...Hospice and Facility shall jointly develop and agree upon the Patient's Joint Plan of Care...Hospice and Facility each shall maintain a copy...Hospice and Facility each shall designate a registered nurse responsible for coordinating the implementation of the JPOC for each Patient...Concurrently with the execution of this Agreement, Hospice and Facility each shall designate one or more individuals to serve as liaisons and facilitate cooperation between the Parties..." Two Exhibits were attached to the Agreement. Exhibit F "Delineation of Nursing and Aide Services" documented hospice RN responsibilities included, "Collaboration with Facility Staff in delivery and updating Joint Plan of Care...Communication and coordination of patient care services of Facility Staff..." and facility RN/LVN responsibilities included, "Coordination with Hospice Staff in</p>	F 526	<p>RESIDENT SPECIFIC:</p> <ul style="list-style-type: none"> - Resident # 5 was affected by this deficient practice. - We have conducted a joint facility IDT meeting with the Hospice Agency on two occasions to correct our weaknesses. One meeting was with our IDT, Hospice Nurse, and family members. This meeting set a clear and present path to update and coordinate the JPC. The family members, hospice and our IDT were all in agreement to the outcomes. -The night shift license nurse who worked 10/21/2016 -10/24/2016 was counseled and educated regarding the importance of assessing and documenting pain levels. -The second meeting occurred with the Hospice Agency Administrator, DON and our IDT and Administrator. The purpose of this meeting was to review what occurred in the early stages of this Hospice patients and what elements need to come into play to be in compliance for a JPC. The ultimate outcome was to agree to do their part and our part to provide excellent Hospice care for the patient. We all agreed that this meeting was fruitful in assuring future compliance with a JPC and free flowing communication on both ends of the equation. <p>*CORRECTIVE ACTION FOR POTENTIAL RESIDENTS THAT MAY BE AFFECTED BY THIS DEFICIENT PRACTICE :</p>		

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F 526	<p>Continued From page 21</p> <p>implementation and update of Joint Plan of Care. Administration of medication...Notifying Hospice of change in symptoms, Patient/family distress..." Exhibit G documented the hospice and facility were both responsible to participate in the development, review, and revision of the Joint Plan of Care.</p> <p>Resident #5 was admitted to the facility on 10/20/16 with multiple diagnoses, including right-sided weakness related to a CVA and terminal metastatic cancer with hospice care in place. Resident #5 died in the facility on 10/25/16, five days after her admission.</p> <p>Resident #5's 10/21/16 "Cancer/Comfort Care/Hospice/Care Plan" facility care plan problem areas included "terminal diagnosis" and "...on Hospice Care." The goals included "kept comfortable" and coordination of care with hospice staff. Approaches included monitor pain/discomfort and implement ordered interventions; listen to "client" and resolve concerns as soon as possible; and medications/lab work as ordered. In addition, an undated, handwritten approach documented, "...unresponsive medicate as directed" follow up with family for any pain complaints.</p> <p>Resident #5's 10/21/16 Self Care Deficit facility care plan identified impaired mobility, decreased strength, easily fatigues and pain as problems. Approaches included to assist Resident #5 with ADLs as needed and record the amount of assistance needed for each ADL. The Point of Care History, for 10/1/16 - 11/30/16, documented Resident #5 needed total assistance by 2 or more people with bed mobility, dressing, and</p>	F 526	<p>-The current and future hospice resident has the potential to be affected by this deficient practice.</p> <p>-The current facility hospice resident plan of care has been reviewed and updated to ensure that it reflects coordination of care between the facility and the current hospice agency.</p> <p>- The hospice nurse for the current hospice resident in the facility was in serviced regarding the importance of coordinating care with specific focus on the following :</p> <ol style="list-style-type: none"> 1.Telephone,verbal or written Order processing 2. Resident current physical, mental and psychosocial status and current needs. 3. The presence of a Joint plan of care. 4. Communicating with the Director of Nursing /Designee, the facility designated IDT team member to coordinate and implement the joint plan of care. <p>*MEASURES(FACILITY SYSTEMS) THAT WILL BE PUT IN PLACE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR:</p> <p>-The night license nurse duties will be updated to include in their daily 24 hour audit checks to physically check all the resident's hard charts with the goal of being able to intercept any unprocessed order and be able to process them upon discovery.</p> <p>-The review for initial coordination of care for new Hospice residents will be added</p>		

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F 526	<p>Continued From page 22</p> <p>toileting and total assistance by 1 to 2 people for personal hygiene.</p> <p>Neither a hospice care plan, nor a Joint Plan of Care between the facility and hospice provider, were found in Resident #5's closed clinical record.</p> <p>On 1/20/17 at 1:30 pm, the BFS [State Survey Agency] received a Collaborative Plan of Care via fax from the facility. This Collaborative Plan of Care was signed by a facility LN on 10/26/16, the day after Resident #5's death.</p> <p>Resident #5's 10/20/16 Discharge Medication Reconciliation Order Report included continuation of a fentanyl 25 mcg/hr patch every 72 hours. Resident #5's 10/20/16 hospice orders included morphine ER 30 mg po BID and morphine sulfate 20 mg/ml solution 0.5-1 ml po every 1-2 hours prn pain.</p> <p>A 10/20/16 facility pain assessment documented Resident #5's pain was crushing, sharp, shooting and stabbing and almost constant at "9" on a scale of 0-10. The October 2016 Medication Flowsheet documented Resident #5's pain was "5" on 10/20/16 night shift and 10/21/16 day shift, "4" on 10/22/16 day shift, then increased to "8" on 10/23/16 day shift, and was "0" on 10/24/16 day shift. The pain was not documented as assessed on the night shift on 10/21/16 through 10/24/16.</p> <p>A 10/22/16 at 10:00 am, hospice physician telephone order documented liquid morphine 20 mg/mL (Roxanol) 1 mL po every hour and to discontinue morphine 30 mg ER effective</p>	F 526	<p>in the agenda during the daily stand up meeting by management.</p> <p>- The License nurse will be in serviced on the following :</p> <p>a. Pain management (with emphasis on the effectiveness of current pain regimen, documenting current pain status)</p> <p>b. The Six Rights of Medication Administration (emphasis on documenting when holding prn meds)</p> <p>c. The Bingham Memorial Skilled Nursing and Rehabilitation Center Controlled Substance Accountability and Distribution Policy #651 with emphasis on the process of documenting controlled medications outside of an automated drug Cabinet .</p> <p>d. The importance of Following Doctor's orders and communicating with the provider when the resident's plan of care needs to be updated.</p> <p>e. F tag 526 Hospice</p> <p>-The IDT care conference for hospice residents will be held within 7 days of admission and monthly thereafter for the first quarter then quarterly and prn thereafter.</p> <p>- The facility will audit the following :</p> <p>1. Any prn controlled medications administered daily to ensure that they are documented in the MAR and the controlled administration record for medications not obtained from the automated drug cabinet.</p> <p>2. Any held medications are documented appropriately and the rationale for holding the medication.</p>		

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F 526	<p>Continued From page 23</p> <p>10/24/16. The order was noted as "received" and "performed" by a hospice nurse.</p> <p>A 10/22/16 facility Occurrence/Med Error Report documented a hospice nurse "noticed roxanol [sic] order was not processed" and it was brought to the charge nurse's attention. The correction at the time of the occurrence was, "Processed order hospice ordered new med order. Processed that order..." The root cause was, "Poor communication between hospice & [facility] staff."</p> <p>On 1/19/17 at 11:15 am, LN #1 said she was the charge nurse on 10/22/16 when a hospice nurse reported the order for morphine solution 20 mg/mL every hour had not been processed. LN #1 said the medication was started immediately. LN #1 also said the hospice nurse who took the 10/22/16 10:00 am order had also signed the order as processed but did not communicate with facility staff about the change. LN #1 said the hospice nurse may have put the order away before the facility staff saw it. Resident #5's October 2016 Medications Flowsheets did not include the order for morphine solution 20 mg/mL 1 mL po every hour.</p> <p>Two more telephone orders by the hospice physician, both dated 10/23/16 at 1:00 pm, discontinued fentanyl 25 mcg/hr and increased the fentanyl to 100 mcg/hr every 72 hours. These orders were also noted as "received" and "performed" by the same hospice nurse. The October 2016 Medications Flowsheets documented Fentanyl 25 mcg/hr patch was administered on 10/20/16 at 8:00 pm. However, Fentanyl 100 mcg/hr was not included in the Medications Flowsheets.</p>	F 526	<p>3. Medication administration record for any blanks and the rationale for no documentation.</p> <p>4. Daily and admission orders to ensure that they are accurate, documented and processed.</p> <p>5. Documentation that there was coordination of care between hospice nurse and the facility nurse for the current and or any future hospice resident.</p> <p>6. A care plan is present for any future hospice resident.</p> <p>*MONITORING A.WHO: -DNS/Designee</p> <p>B.FREQUENCY -will audit daily for 1month , then 3x/week for 1 month ,weekly x 1 month for a period of 12 weeks .Any issue noted will be immediately addressed. The QA committee will review any issues uncovered by the weekly audits and after the initial 12 weeks make a determination related to changing the frequency of those audits.</p> <p>C.START DATE: - March6,2017</p> <p>*DATES WHEN CORRECTIVE ACTION IS COMPLETED: - March 24,2017</p>		

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F 526	Continued From page 24 Resident #5's October 2016 Medications Flowsheets also documented the morphine ER 30 mg was administered on 10/21/16 at 3:00 am and 3:00 pm, held both times on 10/22/16, without explanation, then discontinued. There were blanks in all of the spaces for documentation of the prn morphine solution 20 mg/mL 0.5-1 mL prn every 1-2 hours. The flowsheets also listed morphine solution 20 mg/5 mL (4 mg/mL) 0.5-1 mL po hourly was administered hourly from 7:30 pm - 11:30 pm on 10/23/16; from 12:30 am - 4:30 am, 6:30 am, 11:30 am - 3:30 pm, then 7:30 pm - 11:30 pm on 10/24/16; and 12:30 am - 2:30 am on 10/25/16 with initials circled at 5:30 am and 7:30 am - 10:30 am on 10/24/16, without explanation, and blanks in the spaces for documentation from 4:30 pm - 6:30 pm on 10/24/16. However, an order for morphine solution 20 mg/5 mL (4 mg/mL) 0.5-1 mL hourly was not found in Resident #5's clinical record, nor was it provided by the facility. There was no documented evidence of collaboration between the facility and the hospice provider regarding the pain medication changes in the handwritten hospice notes, dated 10/21/16 at 9:00 am to 10/24/16 at 8:33 pm, facility progress notes, dated 10/21/16 at 5:30 am to 10/25/16 at 4:42 am, or facility Focused Observation Notes, dated 10/22/16, 10/23/16 and 10/24/16. On 10/21/16 at 8:00 am, a hospice nurse requested and received a verbal order for a Foley catheter (brand of indwelling urinary catheter), "essential in maintaining patient comfort throughout the dying process" for Resident #5.	F 526			

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F 526	Continued From page 25 However, there was no documented evidence in the previously noted handwritten hospice notes or facility progress notes of collaboration and coordination between the facility and hospice regarding the Foley catheter. Additionally, facility Focused Observation Notes for 10/22/16, 10/23/16 and 10/24/16, documented a urinary catheter was not in place and Resident #5's October 2016 General Flowsheet did not include a urinary catheter. Resident #5 was harmed when she experienced increased pain and discomfort during her last days of life when the facility and the hospice provider failed to communicate, collaborate, and coordinate with one another regarding pain medication changes and the need for an indwelling urinary catheter for comfort care.	F 526			



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

May 18, 2017

Mark Teckmeyer, Administrator
Bingham Memorial Skilled Nursing & Rehabilitation
98 Poplar Street
Blackfoot, ID 83221-1758

Provider #: 135007

Dear Mr. Teckmeyer:

On **January 19, 2017**, an unannounced on-site investigation of a complaint was conducted at Bingham Memorial Skilled Nursing & Rehabilitation. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007405

ALLEGATION #1:

An identified resident did not receive routine pain medication as ordered throughout the night, and refused repositioning and care because s/he was in too much pain. At one point the resident was crying and stating over and over that s/he wanted to die. The night nurse on duty the night in question did not feel comfortable giving routine morphine to the resident, and was only giving the medication as needed.

FINDINGS:

The clinical record documented the identified resident's pain increased when orders to change scheduled pain medications were not implemented, were not implemented in a timely manner, and/or were not consistently administered per physician orders. The record also contained evidence that the facility and the hospice provider failed to communicate and coordinate the resident's care regarding pain management and comfort care. In addition, a facility nurse said s/he was not comfortable administering morphine hourly as ordered.

Mark Teckmeyer, Administrator
May 18, 2017
Page 2 of 3

The allegation was substantiated and cited at both F 309 and F 526.

ALLEGATION #2:

An identified resident was found covered in feces and urine from the knees to the shoulders. The bed was so saturated that urine was dripping off and pooling on the floor and the resident was placed in a completely different bed. At one point during the night, something was "dripping off the bed." A nurse responded by throwing a towel on the floor to absorb the fluid, but did not address the fact that the resident had been incontinent.

FINDINGS #2:

All residents were observed to be clean, and their beds and bed linens were clean and dry, when the survey team entered the facility and throughout the complaint investigation. Five individual residents said facility staff provided or assisted with toileting and/or incontinence care in a timely manner.

The clinical record documented an identified resident had several episodes of bowel incontinence with loose bowel movements and "large amounts of flatus" and that more incontinence was expected.

A Concern Form documented a complaint that the resident had not been changed since the night shift. The Concern Form documented the identified resident was "found soiled (###) time of complaint" and that the resident was changed and bathed and the bed was changed and "sanitized."

Three Licensed Nurses and two Certified Nursing Assistants who recalled the identified resident said that incontinence care was provided when it was needed and when the resident's family would allow it.

Based on the observations, record reviews and interviews, deficient practice was not identified and there was lack of sufficient evidence to substantiate the allegation.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

An identified resident was not repositioned all night.

Mark Teckmeyer, Administrator
May 18, 2017
Page 3 of 3

FINDINGS #3:

Five individual residents said that facility staff were timely in assisting them with turning and repositioning. None of the residents voiced concerns that they were not being turned or repositioned.

A Concern Form documented a complaint that the resident had not been moved since the night shift. The Form noted that a nurse was seen going into the resident's room approximately five times during the night. The response to the concern documented the resident's family did not want the resident repositioned.

Three Licensed Nurses and two Certified Nursing Assistants who recalled the identified resident said the resident was repositioned on their shifts and according to the family's preference.

Based on the observations, record reviews and interviews, deficient practice was not identified and there was lack of sufficient evidence to substantiate the allegation.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

Based on the findings of the investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this findings letter, as it will be addressed in the provider's Plan of Correction.

If you have questions, comments or concerns regarding our investigation, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

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

David Scott, R.N., Supervisor
Long Term Care

DS/lj