

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

PRINTED: 06/06/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135138	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 06/01/2017
NAME OF PROVIDER OR SUPPLIER TETON POST ACUTE CARE & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 3111 CHANNING WAY IDAHO FALLS, ID 83404		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{F 000}	<p>INITIAL COMMENTS</p> <p>On May 31, 2017 to June 1, 2017, an onsite revisit survey of your facility was conducted to verify correction of deficiencies noted during the survey of Teton Post Acute Care & Rehabilitation was found to be in substantial compliance with federal health care regulations as of May 17, 2017.</p> <p>The surveyor(s) conducting the survey were: Brad Perry, LSW Team Leader Jenny Walker, RN</p>	{F 000}			

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

TITLE

(X6) DATE

Electronically Signed

06/02/2017

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.

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001775	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 06/01/2017
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NAME OF PROVIDER OR SUPPLIER TETON POST ACUTE CARE & REHABILITATIO	STREET ADDRESS, CITY, STATE, ZIP CODE 3111 CHANNING WAY IDAHO FALLS, ID 83404
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{C 000}	<p>16.03.02 INITIAL COMMENTS</p> <p>On May 31, 2017 to June 1, 2017, an onsite revisit survey of your facility was conducted to verify correction of deficiencies noted during the survey of Teton Post Acute Care & Rehabilitation was found to be in substantial compliance with state health care regulations as of May 17, 2017.</p> <p>The surveyor(s) conducting the survey were: Brad Perry, LSW Team Leader Jenny Walker, RN</p>	{C 000}		

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

TITLE

(X6) DATE
06/02/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135138	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/01/2017
NAME OF PROVIDER OR SUPPLIER TETON POST ACUTE CARE & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 3111 CHANNING WAY IDAHO FALLS, ID 83404		
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F 000	<p>INITIAL COMMENTS</p> <p>From May 31, 2017 to June 1, 2017, an onsite revisit and complaint survey of your facility was conducted to verify correction of deficiencies noted during the survey of Teton Post Acute Care & Rehabilitation and was found to be in substantial compliance with federal health care regulations as of May 15, 2017.</p> <p>The surveyors conducting the survey were: Brad Perry, LSW Team Coordinator Jenny Walker, RN</p>	F 000			

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

TITLE

(X6) DATE

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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.



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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RUSSELL S. BARRON – Director

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July 18, 2017

Daniel Kennick, Administrator
Teton Post Acute Care & Rehabilitation
3111 Channing Way
Idaho Falls, ID 83404-7534

Provider #: 135138

Dear Mr. Kennick:

On **June 1, 2017**, an unannounced on-site complaint survey was conducted at Teton Post Acute Care & Rehabilitation. The complaint was investigated in conjunction with the facility's on-site follow-up survey conducted May 31, 2017 through June 1, 2017.

Call lights for the identified resident and most other residents were observed throughout the survey. The identified resident and several other residents were observed for wet and soiled incontinent briefs. Staff were observed for finding other staff to assist with residents who required two-person assistance with cares.

The clinical record of the identified resident and three other residents' records were reviewed for Quality of Care concerns. The facility's Grievance file was reviewed, as well as the Incident and Accident reports for April and May 2017. The facility's Resident Council minutes from March through May 2017 were reviewed.

The identified resident, three of the identified resident's Interested Parties, several other residents, several staff members, the Director of Nursing, the Director of Therapy, a Social Worker, and the Administrator were interviewed regarding Quality of Care concerns. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007520

ALLEGATION #1:

The Reporting Party said an identified resident's call light was not accessible and the resident soiled him/her self. The issue was brought forward by the resident's Interested Party, but the call light continued to be out of reach of the resident.

FINDINGS #1:

Call light times and call light placement for the identified resident and most other residents were observed throughout the survey and call lights were within reach and call lights were answered in a timely manner. The identified resident and two other residents were observed for wet and soiled incontinent briefs and no concerns were identified.

The identified resident and three other residents' clinical record did not document a concern with call lights. The facility's Resident Council minutes from March through May 2017 did not document a concern with call light placement or call light response times.

The identified resident said he/she did not have a concern with call light placement or call light response times. Three of the identified residents' Interested Parties said they were aware of a call light placement concern, but it had been addressed to their satisfaction and that there were no concerns regarding residents' incontinent issues. Several other residents said call light placement and call light response times was not a concern. Several staff members and the Director of Nursing said call lights were placed within reach of the residents and were answered in a timely manner. The Director of Therapy said she was asked to check on the identified resident by an Interested Party and the identified resident had his/her call light within reach, but he/she could not remember where it was at so it was clipped higher on the resident's chest where the resident could see it better. A Social Worker said she did not know of any call light concerns. The Administrator said whenever concerns were brought to him, he would do his best to resolve those concerns, including call lights.

Based on observation, record review, resident, Interested Party and staff interview, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

A staff member told an identified resident he/she would be back with another staff member to assist him/her, but did not come back and the resident soiled him/her self.

Daniel Kennick, Administrator
July 18, 2017
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FINDINGS #2:

The identified resident and several other residents were observed for wet and soiled incontinent briefs and no concerns were identified. Staff were observed for finding other staff to assist with residents who required two-person assistance with cares and no concerns were identified.

The identified resident and two other residents' clinical records did not document a concern with incontinent needs. The facility's Resident Council minutes from March through May 2017 did not document a concern with staff not addressing residents' needs.

The identified resident said he/she did not have a concern with staff assistance. Three of the identified resident's Interested Parties said staff assisted the resident and they had no concerns regarding incontinent issues. Several other residents said their needs were met and staff would come back when they needed additional assistance. Several staff members and the Director of Nursing said residents were assisted in a timely manner.

Based on observation, record review, resident, Interested Party and staff interview, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

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

Sincerely,

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

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

DS/lj