



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

C.L. "BUTCH" OTTER – Governor  
RUSSELL S. BARRON – 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](mailto:fsb@dhw.idaho.gov)

August 5, 2017

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

Provider #: 135140

Dear Mr. Bowman:

On **July 26, 2017**, we conducted an on-site revisit and a complaint investigation to verify that your facility had achieved and maintained compliance. We presumed, based on your allegation of compliance, that your facility was in substantial compliance as of **May 31, 2017**. However, based on our on-site revisit we found that your facility is not in substantial compliance with the following participation requirements:

- **F0156 -- S/S: F -- 483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18) -- Notice Of Rights, Rules, Services, Charges**
- **F0281 -- S/S: D -- 483.21(b)(3)(i) -- Services Provided Meet Professional Standards**
- **F0283 -- S/S: D -- 483.21(c)(2)(i)-(iii) -- Anticipate Discharge: Recap Stay/final Status**
- **F0309 -- S/S: E -- 483.24, 483.25(k)(1) -- Provide Care/services For Highest Well Being**
- **F0323 -- S/S: E -- 483.25(d)(1)(2)(n)(1)-(3) -- Free Of Accident Hazards/supervision/devices**
- **F0328 -- S/S: D -- 483.25(b)(2)(f)(g)(5)(h)(i)(j) -- Treatment/care For Special Needs**
- **F0441 -- S/S: D -- 483.80(a)(1)(2)(4)(e)(f) -- Infection Control, Prevent Spread, Linens**
- **F0520 -- S/S: F -- 483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) -- Qaa Committee-Members/meet Quarterly/plans**
- **F0166 -- S/S: D -- 483.10(j)(2)-(4) -- Right To Prompt Efforts To Resolve Grievances**
- **F0241 -- S/S: D -- 483.10(a)(1) -- Dignity And Respect Of Individuality**
- **F0248 -- S/S: D -- 483.24(c)(1) -- Activities Meet Interests/needs Of Each Res**
- **F0249 -- S/S: E -- 483.24(c)(2)(i)(ii) -- Qualifications Of Activity Professional**

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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 **August 15, 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.
- 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*.

Josh Bowman, Administrator  
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As noted in the Bureau of Facility Standards' letter of **May 12, 2017**, following the survey of **April 21, 2017**, we have already made the recommendation to the Centers for Medicare and Medicaid Services (CMS) for Denial of Payment for New Admissions effective **July 21, 2017** and termination of the provider agreement on **October 21, 2017**, if substantial compliance is not achieved by that time. The findings of non-compliance on **July 26, 2017**, has resulted in a continuance of the remedy(ies) previously mentioned to you by the CMS. On August 3, 2017, CMS notified the facility of the intent to impose the following remedies:

- DPNA made on or after July 21, 2017.

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

If you believe the 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, 0009; phone number: (208) 334-6626, option 2; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You may also contest scope and severity assessments for deficiencies, which resulted in a finding of SQC or immediate jeopardy. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

<http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/NursingFacilities/tabid/434/Default.aspx>

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

- BFS Letters (06/30/11)

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

This request must be received by **August 15, 2017**. If your request for informal dispute resolution is received after **August 15, 2017**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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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 cursive script that reads "Debby Ransom". The signature is written in black ink and is positioned above the printed name and title.

Debby Ransom, RN, RHIT  
Chief, Bureau of Facility Standards

dr/lj  
Enclosures

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

PRINTED: 10/23/2017  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135140</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R</b> <b>07/26/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>MADISON CARRIAGE COVE SHORT STAY REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>410 WEST 1ST NORTH</b> <b>REXBURG, ID 83440</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{F 000}	INITIAL COMMENTS  The following deficiencies were cited during the follow up and complaint investigation survey conducted at the facility from July 25, 2017 to July 26, 2017.  The surveyors conducting the survey were:  David Scott, RN, Team Coordinator Nina Sanderson, LSW  Abbreviations:  AD = Activities Director ADL = Activities of Daily Living ADON = Assistant Director of Nursing AIT = Administrator in Training BG = Blood Glucose (sugar) BID =Two times a day CNA = Certified Nursing Assistant CPAP = Continuous Positive Airway Pressure LN = Licensed Nurse MAR = Medication Administration Record MDS = Minimum Data Set mg = milligram(s) mg/dl = milligrams per deciliter MRSA = Methicillin Resistant Staphylococcus Aureus NN = Nurse's Notes QA = Quality Assurance Sats = Oxygen Saturations S/S = Signs and Symptoms TAR = Treatment Administration Record	{F 000}			
{F 156} SS=F	483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES  (d)(3) The facility must ensure that each resident remains informed of the name, specialty, and	{F 156}		9/5/17	

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

TITLE

(X6) DATE

Electronically Signed

08/15/2017

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 156}	<p>Continued From page 1</p> <p>way of contacting the physician and other primary care professionals responsible for his or her care.</p> <p>§483.10(g) Information and Communication.</p> <p>(1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility.</p> <p>(g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including:</p> <p>(i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes -</p> <p>(A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section;</p> <p>(B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act.</p> <p>(C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the</p>	{F 156}			

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{F 156}	Continued From page 2 community and the Medicaid Fraud Control Unit; and  (D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community.  (ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.) [§483.10(g)(4)(ii) will be implemented beginning November 28, 2017 (Phase 2)]  (iii) Information regarding Medicare and Medicaid eligibility and coverage; [§483.10(g)(4)(iii) will be implemented beginning November 28, 2017 (Phase 2)]  (iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program; [§483.10(g)(4)(iv) will be implemented beginning November 28, 2017 (Phase 2)]	{F 156}			

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{F 156}	Continued From page 3  (v) Contact information for the Medicaid Fraud Control Unit; and [§483.10(g)(4)(v) will be implemented beginning November 28, 2017 (Phase 2)]  (vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community.  (g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives:  (i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and  (ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property	{F 156}			

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{F 156}	<p>Continued From page 4 in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community.</p> <p>(g)(13) The facility must 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>(g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay.</p> <p>(i) 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.</p> <p>(ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any.</p> <p>(iii) Receipt of such information, and any amendments to it, must be acknowledged in writing;</p> <p>(g)(17) The facility must--</p> <p>(i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of-</p>	{F 156}			

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{F 156}	<p>Continued From page 5</p> <p>(A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged;</p> <p>(B) 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</p> <p>(ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in paragraphs (g)(17)(i)(A) and (B) of this section.</p> <p>(g)(18) 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/ Medicaid or by the facility's per diem rate.</p> <p>(i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.</p> <p>(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.</p> <p>(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's</p>	{F 156}			

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{F 156}	<p>Continued From page 6</p> <p>per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.</p> <p>(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.</p> <p>v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on review of the facility's admissions agreement and staff interview, it was determined the facility failed to ensure residents were made aware of their right to protection of their private information and option not to participate in research at the time of their admission. This deficient practice had the potential to impact any resident admitted to the facility, and created the potential for:</p> <ul style="list-style-type: none"> <li>*Residents to be financially exploited when their private information was used for solicitation purposes; and</li> <li>*Residents to become participants in experimental research without their knowledge or consent.</li> </ul> <p>Findings include:</p> <p>On 7/15/17, the facility's Administrator provided a copy of the facility's Admission Agreement. The Agreement had no implementation date. The Agreement documented, in the section entitled, "Notice of Privacy Practices...This Notice</p>	{F 156}	<p>Preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the accuracy or truthfulness of any facts alleged or any conclusions set forth in this allegation of deficiencies by the State Licensing Authority. Accordingly, the facility has drafted this Plan of Correction in accordance with Federal and State Laws which mandate the submission of a Plan of Correction as a condition for participating in the Medicare and Medicaid program. This Plan of Correction shall constitute this facility's credible allegation compliance with this section.</p> <p>F 156 SS=F 483.10 (d)(3)(g)(1)(4)(5)(13)(16)-(18) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p>		

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{F 156}	<p>Continued From page 7</p> <p>Describes How Your Medical Information May Be Used and Disclosed...":</p> <p>* "Fundraising Activities. We may use health information about you to contact you in an effort to raise money as part of a fundraising effort. We may disclose health information to a foundation related to the Facility so that the foundation may contact you in raising money for the Facility..."</p> <p>*Research. Under certain circumstances, we may use and disclose health information about you for research purposes. For example, a research project may involve comparing the health and recovery of all Residents who received one medication to those who received another, for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed a research project and its use of health information, trying to balance the research needs with Residents' need for privacy of their health information. Before we use or disclose health information for research. the project will have been approved through this research approval process. We may, however, disclose health information about you to people preparing to conduct a research project so long as the health information they review does not leave the facility."</p> <p>On 7/25/17 at 5:15 pm,. Administrator identified the Admission Agreement as being in effect "since before I started here." The Administrator stated he had worked at the facility since mid-May 2017. The Administrator stated he was not aware the facility was soliciting residents for "fundraising". agreed that it should not be included in the Agreement. The Administrator</p>	{F 156}	<p>The facility does ensure that residents are made aware of their right to protection of their private information and option not to participate in research at the time of their admission.</p> <p>Corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice</p> <p>The admission agreement was modified and eliminated the following clauses from the document:</p> <p>Fundraising Activities. We may use health information about you to contact you in an effort to raise money as part of a fundraising effort. We may disclose health information to a foundation related to the Facility so that the foundation may contact you in raising money for the Facility.</p> <p>Research. Under certain circumstances, we may use and disclose health information about you for research purposes. For example, a research project may involve comparing the health and recovery of all Residents who received one medication to those who received another, for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of health information, trying to balance the research needs with the Residents <input type="checkbox"/> need for privacy of their health information.</p>	

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{F 156}	Continued From page 8 stated he would amend the agreement to remove that paragraph. The Administrator stated after reading the section on research, the facility needed to ensure the Agreement specified participation in research and any related disclosure of private information was voluntary in nature, and not a condition of admission to the facility. The Administrator stated the Agreement would be amended.	{F 156}	<p>Before we use or disclose health information, the project will have been approved through the research approval process. We may, however, disclose health information about you to people preparing to conduct a research project so long as the health information they review does not leave the facility.</p> <p>All current guests will receive an addendum explaining the modifications that were made to the Admission Agreement. All future guests will receive the modified Admission Agreement.</p> <p>Education shall be provided to the Administrator.</p> <p>Identification of other residents having the same potential to be affected by the same practice and what corrective actions taken includes the following:</p> <p>All current and future residents have the potential to be affected by this deficient practice.</p> <p>Admission Agreement was modified and all guests will receive the correct the updated Admission Agreement.</p> <p>Measures that will be put into place or systematic changes you will make to ensure that the deficient practice does not recur includes the following:</p> <p>To ensure the deficient practice does not recur,</p>		

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NAME OF PROVIDER OR SUPPLIER  <b>MADISON CARRIAGE COVE SHORT STAY REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>410 WEST 1ST NORTH</b> <b>REXBURG, ID 83440</b>		
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{F 156}	Continued From page 9	{F 156}	<p>The admission agreement was modified on 7.26.17</p> <p>All current guests will receive an addendum explaining the modifications that were made to the Admission Agreement. All future guests will receive the modified Admission Agreement</p> <p>How the corrective actions will be monitored to ensure the deficient practice will not recur:</p> <p>Monitoring will be done through:</p> <p>The Administrator or Designee will conduct 3 random audits to verify current admission agreement is in place.</p> <p>Monitoring will start on 9/5/2017 This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3</p> <p>The Administrator or Designee will present to the quarterly QA Committee meeting any findings and/or corrective actions taken</p> <p>Compliance, continuation/discontinuation of monitoring will be discussed during the QA Committee quarterly meeting.</p> <p>9/5/2017</p>		
F 248 SS=D	483.24(c)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES  (c) Activities.	F 248		9/5/17	

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F 248	Continued From page 10  (1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure there was an ongoing activity program to meet individual resident needs. This was true for 1 of 6 residents (#8) sampled for quality of life concerns. The deficient practice created the potential for harm if residents experienced boredom or depression when not meaningfully engaged in their day. Findings include:  Resident #8 was readmitted to the facility on 5/4/17 with diagnoses which included history of a femoral neck fracture, edema, atrial fibrillation, hypertension, and major depression.  Resident #8's 5/11/17 Admission Minimum Data Set (MDS) documented she was cognitively intact, had no current symptoms of depression, and required extensive assistance from two persons for most activities of daily living and mobility. The MDS documented the interview for Preferences for Customary Routine and Activities was not conducted with the resident, family, or staff.	F 248	F 248 SS=D 483.24 (c)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RESIDENT  The facility does ensure that there is an ongoing activity program that meets individual resident needs  Corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice  Resident #8 will be assessed for activity preferences. Care plan will be updated with preferences to help meet her individual activity needs.  Identification of other residents having the same potential to be affected by the same practice and what corrective actions taken includes the following:  All residents have the potential to be affected by this deficient practice		

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F 248	<p>Continued From page 11</p> <p>Resident #8's Activities Care Plan, initiated 5/17/17, documented a focus of, "Guest has little or no interest in activity involvement and wishes to not participate. Invite and lightly encourage participation in activities of interest." The care plan documented only one intervention, "Monitor behavior daily for [signs and symptoms] of depression and notify [physician] as indicated."</p> <p>On 7/25/17 at 2:20 pm, Resident #8 was laying on her back in her bed. Resident #8 stated she spent most of her day in bed to elevate her legs for edema relief. She stated she found herself without much to keep her busy throughout the day because she did not like daytime television. Resident #8 stated the facility did not offer her anything to do, so she had taken it upon herself to organize her own daily routine. Resident #8 stated her family brought her word search puzzles, which she worked on in the morning, then played solitaire on her tablet in the afternoon. Resident #8 stated she was just about to turn on her tablet, but was "stalling" because she was becoming bored with solitaire. Resident #8 stated she was unaware she could use her tablet to purchase books or look at the Internet. Resident #8 stated, "No one has ever talked to me about that kind of thing." Resident #8 stated she had previously enjoyed quilting, and pointed to a small quilt hanging on her wall that she had made. Resident #8 described in detail the method she used to make the quilt, and stated she had many more like it at home. Resident #8 stated, "I usually just do the puzzles and the [tablet], but visiting for a change is very nice."</p> <p>The facility's activity calendar for 7/25/17</p>	F 248	<p>All current residents will be interviewed regarding activity preferences and care plan will be updated as indicated</p> <p>Administrator shall ensure that the facility has a qualified individual overseeing the activity program</p> <p>All staff will be educated on how to assist in promoting activities to meet individual resident needs</p> <p>Measures that will be put into place or systematic changes you will make to ensure that the deficient practice does not recur includes the following:</p> <p>To ensure the deficient practice does not recur,</p> <p>Calendar shall be reviewed by the Administrator to verify that the quantity and quality of activities are appropriate for the residents of the facility.</p> <p>During monthly resident council meetings, residents will be given the opportunity to give input on activity content to help promote individual resident needs.</p> <p>Activity Calendar will be posted in every room as well as on a larger medium posted in public view.</p> <p>Future Admission comprehensive care plans will reflect activity preferences.</p>		

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F 248	<p>Continued From page 12</p> <p>documented no activities were scheduled or planned for that day. Between 7/24/17 and 7/31/17, the facility activity calendar documented "Sacrament" every Sunday at 6:00 pm, "Bingo" every Wednesday at 3:30 pm, "Golf Cart Rides" on 7/28/17 at 3:00 pm, and "Movie and Popcorn" on 7/29/17 at 1:00 pm. No other activities were documented as scheduled.</p> <p>On 7/25/17 at 2:45 pm, LN #1 stated she had worked at the facility for approximately 6 months, and cared for Resident #8 regularly. LN #1 stated the facility always had board games and puzzles available for residents, including Resident #8, and she believed the activities staff made residents aware those things were available. LN #1 was unable to state how a resident would engage in a board game independently with no opponent. LN #1 stated she did not know what Resident #8's leisure interests were, her preference was to remain in bed and elevate her legs. LN #1 confirmed the activities calendar was blank, for Monday, Tuesday, and Thursday from 7/24/17 through 7/31/17. LN #1 stated the facility currently did not have activities staff, but the CNAs did what they could towards seeing to resident leisure needs. LN #1 stated the previous day, the CNAs conducted a resident scavenger hunt and then provided ice cream. LN #1 was not sure if the residents had expressed an interest in conducting a scavenger hunt, or what, if anything, had been done for Resident #8's leisure needs.</p> <p>On 7/25/17 at 2:45 pm, CNA #2 stated she had been hired by the facility the previous week to start working in "activities," but she had to finish her current schedule as a CNA before she could</p>	F 248	<p>How the corrective actions will be monitored to ensure the deficient practice will not recur:</p> <p>Monitoring will be done through:</p> <p>The Administrator or designee shall conduct periodic audits to verify the following in relation to the Activities program:</p> <p>" The Activity Calendar has sufficient quality and quantity of activities for each day,</p> <p>" Every resident has a copy of the monthly calendar</p> <p>" Activity Calendar is posted on large medium in public view</p> <p>" That previous month's resident council has minutes in relation to residents input on activity program and that those minutes are reviewed and implemented as such can be reasonably accommodated.</p> <p>" That residents are satisfied with the activities offered through random resident interviews</p> <p>" That documentation reflects that individualized activities are being offered as planned through random documentation audits.</p> <p>Monitoring will start on 9/5/2017</p>		

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F 248	Continued From page 13 start in that program. CNA #2 stated she was not sure if she was to be the Activities Director, and thought perhaps she was just going to be "part of the staff." CNA #2 stated she had not received any training in activities, and did not think she was scheduled for any training. CNA #2 stated she had been told the previous Activities Director had done an activities assessment for Resident #8, but was not sure what that assessment entailed, or what the resident's preferences were.  On 7/25/17 at 5:15 pm, the Administrator stated the previous Activities Director had recently resigned, and CNA #2 had been hired as a replacement. The Administrator stated he was unaware of any specific activities plan for Resident #8.	F 248	This will be done monthly x 4 months  The Administrator or designee shall audit 3 random activity care plans to ensure individual preferences are listed.  Monitoring will start on 9/5/2017 This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3  The Administrator or Designee will present to the quarterly QA Committee meeting any findings and/or corrective actions taken  Compliance, continuation/discontinuation of monitoring will be discussed during the QA Committee quarterly meeting.		
F 249 SS=E	483.24(c)(2)(i)(ii) QUALIFICATIONS OF ACTIVITY PROFESSIONAL  (c)(2) The activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who-  (i) Is licensed or registered, if applicable, by the State in which practicing; and  (ii) Is: (A) Eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or  (B) Has 2 years of experience in a social or recreational program within the last 5 years, one of which was full-time in a therapeutic activities	F 249		9/5/17	

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F 249	<p>Continued From page 14 program; or</p> <p>(C) Is a qualified occupational therapist or occupational therapy assistant; or</p> <p>(D) Has completed a training course approved by the State. This REQUIREMENT is not met as evidenced by: Based on interview it was determined the facility did not provide direction for the activities program from a qualified professional. This deficient practice had the potential to impact any resident wishing to have their leisure interests met in the facility, and created the potential for harm if residents were bored or under stimulated due to lack of provision of leisure services. Findings include:</p> <p>On 7/25/17 at 2:45 pm, LN #1 stated the facility's previous Activities Director (AD) had resigned as of the previous Friday, and the facility currently had no activities staff.</p> <p>On 7/25/17 at 2:45 pm, CNA #2 stated she had been hired into the activities department to replace the previous AD, but had to finish out her scheduled time as a CNA before she could assume her new duties. CNA #2 stated she was not sure if she was supposed to be the director of the Activities program, and thought she "might just be activities staff." CNA #2 stated she had no training from the facility or otherwise as an AD. CNA #2 stated she did not have a professional credential as an AD.</p> <p>On 7/25/17 at 5:15 pm, the Administrator stated the previous AD had resigned and her last day</p>	F 249	<p>F 249 SS=E 483.24 (c)(2)(i)(ii) QUALIFICATIONS OF ACTIVITY PROFESSIONAL</p> <p>The facility does ensure that the activities program is directed by a qualified professional</p> <p>Corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice</p> <p>The facility secured a qualified professional on 8/9/17 to oversee the activity program</p> <p>Education shall be provided to the administrator in regards to the needed qualifications to oversee a SNF activity program.</p> <p>Identification of other residents having the same potential to be affected by the same practice and what corrective actions taken includes the following:</p> <p>All residents have the potential to be affected by this deficient practice.</p>		

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F 249	Continued From page 15 had been the previous Friday, and CNA #2 had been cross-trained to perform the AD duties. The Assistant Director of Nursing (ADON) stated she had trained CNA #2, which entailed orientation to Section F of the MDS, and training to incorporate range of motion exercises into the activities program. The Administrator in Training (AIT) stated the facility planned to enroll CNA #2 in an "online course" to obtain the appropriate credential to become AD.	F 249	A qualified professional was secured on 8/9/17 to oversee the activity program.  Measures that will be put into place or systematic changes you will make to ensure that the deficient practice does not recur includes the following:  To ensure the deficient practice does not recur,  The facility employs qualified therapists that can provide oversight over the activity program on an interim basis in the event the Activity Director leaves or lapse of succession.  How the corrective actions will be monitored to ensure the deficient practice will not recur:  Monitoring will be done through:  QA committee shall monitor that we have a qualified professional running the activity program.  9/5/2017		
{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-	{F 281}		9/5/17	

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{F 281}	<p>Continued From page 16</p> <p>(i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, it was determined the facility failed to ensure facility Licensed Nurses (LNs) were following physician's orders. This was true for 1 of 8 residents (# 31) sampled for professional standards of care. The deficient practice created the potential for harm when a resident received an antihypertensive medication without first monitoring the resident's heart rate. Findings include:</p> <p>The Wolters Kluwer 2018 Nursing Drug Handbook documented Cozaar was classified as an antihypertensive (blood pressure) medication. Under Contraindications and Cautions, the Handbook documented, "Overdose [Signs and Symptoms]: Hypotension, tachycardia [rapid heartbeat], bradycardia [slow heartbeat]."</p> <p>Resident #31 was admitted to the facility on 4/20/17 with diagnoses which included hypertension. Resident #31 discharged from the facility on 7/5/17.</p> <p>Resident #31's 5/17/17 Order Summary Report (Physician's Recapitulation Orders) documented: *Hold Blood Pressure Medications if Systolic [blood pressure is less than] 100 [millimeters of mercury] systolic [the top number of a blood pressure reading] or pulse [heart rate] less than 80. *Cozaar Tablet 50 mg every morning.</p> <p>Resident #31's Medication Administration Record (MAR) for June 2017, and 7/1/17 through 7/5/17,</p>	{F 281}	<p>F 281 SS=D 483.21 (b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The facility does ensure that all residents have individualized parameters according to their diagnosis and medications.</p> <p>Corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice</p> <p>Resident # 31 is no longer a resident in facility</p> <p>Identification of other residents having the same potential to be affected by the same practice and what corrective actions taken includes the following:</p> <p>Residents receiving medications that require parameters have the potential to be affected by this deficient practice.</p> <p>Medication review to be completed on all residents to ensure appropriate parameters are in place</p> <p>Drug regimen review to be completed on all current residents by pharmacist and recommendations to physician for clarification as indicated</p> <p>All licensed nurses to be educated on</p>		

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{F 281}	<p>Continued From page 17</p> <p>documented the Cozaar was administered daily. A blood pressure reading was documented on the MAR in conjunction with the Cozaar administration. Pulse rates were not documented on the MAR.</p> <p>On 7/26/17 at 4:20 pm, the Assistant Director of Nursing (ADON) stated the order to hold Resident #31's blood pressure medication if certain parameters were met was related to the use of Cozaar specifically. The ADON stated Resident #31's MARs did not document the resident's pulse rate prior to administration of Cozaar. The ADON provided a Weights and Vital Signs Summary sheet for Resident #31. The Summary sheet documented the resident's pulse rate at various times throughout the day. The ADON stated the Summary sheet documented the time the readings were entered into the record, not when they were taken. The ADON stated there was no way to determine whether any of the readings were taken or evaluated prior to administering Resident #31's Cozaar.</p>	{F 281}	<p>need of following physician orders with attention to recommended parameters</p> <p>Measures that will be put into place or systematic changes you will make to ensure that the deficient practice does not recur includes the following:</p> <p>During our monthly Pharmacy review the pharmacist shall review all medications of residents to verify the following:</p> <p>" Medications requiring parameters are reviewed for correctness " Medications that should have parameters but have none specified will have parameters assessed and developed during the meeting</p> <p>Parameters with corresponding instructions will be addressed by the Physician and relayed to the facility.</p> <p>How the corrective actions will be monitored to ensure the deficient practice will not recur:</p> <p>Monitoring will be done through:</p> <p>Director of Nursing or Designee will perform 3 random audits of medication orders to ensure specified parameters are completed per physician orders.</p> <p>Monitoring will start on 9/5/2017 This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3</p>		

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{F 281}	Continued From page 18	{F 281}	The DON or Designee will present to the quarterly QA Committee meeting any findings and/or corrective actions taken		
{F 283} SS=D	<p>483.21(c)(2)(i)-(iii) ANTICIPATE DISCHARGE: RECAP STAY/FINAL STATUS</p> <p>(c)(2) Discharge Summary</p> <p>When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following:</p> <p>(i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results.</p> <p>(ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative.</p> <p>(iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter).</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility did not provide a thorough</p>	{F 283}	<p>Compliance, continuation/discontinuation of monitoring will be discussed during the QA Committee quarterly meeting.</p> <p>9/5/2017</p> <p>F 283 SS=D 483.21 (c)(2)(i)-(iii)</p>	9/5/17	

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NAME OF PROVIDER OR SUPPLIER  <b>MADISON CARRIAGE COVE SHORT STAY REHABILITATION</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>410 WEST 1ST NORTH</b> <b>REXBURG, ID 83440</b>		
(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 283}	<p>Continued From page 19</p> <p>summary when residents discharged from the facility. This was true for 2 of 2 residents (#s 30 and 31) sampled for discharge. The deficient practice created the potential for harm if follow-up providers did not have sufficient information to continue care, or residents did not understand their health conditions. Findings include:</p> <p>1. Resident #31 was admitted to the facility on 4/20/17 with diagnoses which included atrial fibrillation, displaced fracture of the fifth metatarsal on the right foot, history of corneal transplant, hypertension, diabetes mellitus, gout, and sleep apnea. Resident #31 discharged from the facility on 7/5/17.</p> <p>Resident #31's Nurse's Notes documented the resident used a CPAP (Continuous Positive Airway Pressure) machine while sleeping for his diagnosis of sleep apnea on 8 occasions between 5/3/17 and 6/12/17.</p> <p>On 6/14/17, a physician's order for Resident #31 documented he needed a walker for ambulation, as he would be non-weight bearing on his effected leg for 4-8 more weeks.</p> <p>Resident #31's Treatment Administration Record (TAR) for July 2017 documented for 7/5/17, the day of the resident's discharge, that he required a walking boot on his right foot related to his fracture, and tubigrips (compression device) to his right lower leg daily for edema management.</p> <p>On 7/5/17 at 10:06 am, a Check Out Orders form in Resident #31's record documented the resident was discharging home with diagnoses of "displaced fracture of fifth metatarsal bone, right</p>	{F 283}	<p>ANTICIPATE DISCHARGE: RECAP STAY/FINAL STATUS</p> <p>The facility does ensure all residents have an individualized discharge summary according to their diagnoses, disease processes, medications and will have all discharge needs and instructions provided to them as a recapitulation of their stay in written form.</p> <p>Corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice</p> <p>Resident #30 no longer resides in facility Resident #31 no longer resides in facility</p> <p>Identification of other residents having the same potential to be affected by the same practice and what corrective actions taken includes the following:</p> <p>Any resident that discharges from facility has the potential to be affected by this deficiency.</p> <p>A discharge summary has been created to include the following: " Recapitulation of the resident's stay " Final Summary of the resident's status " Reconciliation of all pre-discharge medications with post-discharge medications</p> <p>IDT will be educated on discharge process including completion of discharge</p>	

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{F 283}	<p>Continued From page 20</p> <p>foot, diabetes, hypertension." The form did not document any of Resident #31's additional diagnoses. The form did not document the course of Resident #31's illness, treatment, or therapy. The form did not document Resident #31's treatments of the walking boot or tubigrips. The form contained an area to check which medical equipment needs the resident had at the time of discharge. All items in this area remained unchecked, including the areas for a walker and a CPAP machine. The form documented for "Medications" to see a Medication Reconciliation form, but no such form was attached to the Check out Orders.</p> <p>On 7/26/17 at 4:20 pm. the Assistant Director of Nursing (ADON) stated that she thought sending a list of current medications with the resident at the time of discharge met the regulatory requirement for a discharge summary.</p> <p>2. Resident #30 was admitted to the facility on 7/13/17 with diagnoses which included spinal fusion and Methicillin-Resistant Staphylococcus Aureus (MRSA) in his nares. Resident # 30 discharged from the facility on 7/21/17.</p> <p>Resident #30's admission orders to the facility included the Resident #30 was to have contact isolation precautions initiated.</p> <p>A physician's order dated 7/18/17 for Resident #30 discontinued contact isolation precautions.</p> <p>On 7/20/17, Resident #30's physician provided an order for a front wheeled-walker.</p> <p>On 7/21/17, Resident #30 signed a "Release of</p>	{F 283}	<p>Measures that will be put into place or systematic changes you will make to ensure that the deficient practice does not recur includes the following:</p> <p>To ensure the deficient practice does not recur,</p> <p>New discharge summary sheet will be completed by appropriate departments on each planned discharge and the resident shall be given a copy and educated on the discharge summary plan that is to be followed.</p> <p>How the corrective actions will be monitored to ensure the deficient practice will not recur:</p> <p>Monitoring will be done through:</p> <p>The DON or Designee will conduct 3 random audits of discharged residents to ensure discharge summary was completed with appropriate education needs.</p> <p>Monitoring will start on 9/5/2017 This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3</p> <p>The DON or Designee will present to the quarterly QA Committee meeting any findings and/or corrective actions taken</p> <p>Compliance, continuation/discontinuation of monitoring will be discussed during the</p>		

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{F 283}	Continued From page 21 Responsibility and Receipt of Medication Upon Discharge" form, which documented the resident took the remainder of his medication supply with him at the time of discharge.  On 7/21/17 at 11:47 am, Resident #30's NNs documented a "Check Out Summary." The Summary documented Resident #30 was discharging to his home with home health services. There was no documentation that the resident or receiving care agency was provided with information regarding the resident's diagnoses, or course of illness or treatment.  On 7/26/17 at 4:20 pm the ADON stated that she thought sending a list of current medications with the resident at the time of discharge met the regulatory requirement for a discharge summary.	{F 283}	QA Committee quarterly meeting.  9/5/2017		
{F 309} SS=E	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 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of	{F 309}		9/5/17	

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{F 309}	Continued From page 22 practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following:  (k) Pain Management. 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.  (l) 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. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure diabetic residents' physicians were notified of hypo/hyperglycemic assessments as specified by care plan and facility policy. This was true for 4 of 4 residents reviewed for diabetic management (#s 7 28, 29, and 31) and had the potential for harm if physicians were not given the opportunity to consider treatment options for residents with diabetes mellitus. The facility also failed to assess Resident #31's blood glucose (BG) levels prior to administering oral diabetic medications and Resident #29 received insulin injections without physician-ordered BG parameters. These failed practices involving Residents #29 and #31 had the potential to cause harm if staff administered medications not appropriate for the BG level. Findings include:	{F 309}	F 309 SS=E 483.24, 483.25 (k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  The facility does ensure all residents have individualized parameters according to their diagnoses and medications according to their physician orders.  Corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice  Resident #7 orders sent to MD for clarification on BG parameters Resident #28 orders sent to MD for clarification BG parameters		

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{F 309}	Continued From page 23  1. Resident #7 was admitted to the facility on 10/31/16 with diagnoses that included Type II diabetes mellitus.  The facility's Diabetic Care Policy and Procedure, revised May 2017, documented: * "... standard is to notify [the] physician if [blood glucose (BG) level] less than 70 [mg/dl - milligrams per deciliter] or greater than 350 [mg/dl] ..." * "MD notification as indicated by assessment." * "Develop protocols for hypo/hyperglycemia with Medical Director ... which are reviewed annually." * "[Staff] orientation topics and training annually includes ... physician notification of abnormal parameters ..." For BGs [greater than] 350 [mg/dl] - recheck the resident's blood sugar and notify the physician.  Resident #7's physician's orders, dated 6/20/17, documented staff was to provide Novolog insulin per sliding scale before meals when BGs exceeded 150 mg/dl as follows (all measurements milligrams per deciliter - mg/dl):  * 151 - 200: 2 units * 201 - 250: 4 units * 251 - 300: 6 units * 301 - 350: 8 units * 351 - 400: 10 units * 401 - 450: 12 units  The resident's care plan, dated 6/19/17, documented, "BGs greater than 350 [mg/dl] notify the physician immediately. Notify the physician as soon as possible when: Glucose values are greater than 250 mg/dl within a 24-hr [hour]"	{F 309}	Resident #29 no longer resides in facility Resident #31 no longer resides in facility  Identification of other residents having the same potential to be affected by the same practice and what corrective actions taken includes the following:  All residents requiring blood glucose monitoring have the potential to be affected by this deficient practice.  Blood glucose policy and procedure reviewed and updated  Physician Orders of residents requiring blood glucose monitoring will be sent to MD to verify appropriate parameters are in place  All licensed nurses educated on hypo/hyperglycemia policy and procedure.  Measures that will be put into place or systematic changes you will make to ensure that the deficient practice does not recur includes the following:  Blood glucose policy and procedure reviewed and updated  Physician Orders of residents requiring blood glucose monitoring will be sent to MD to verify appropriate parameters are in place  How the corrective actions will be		

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{F 309}	<p>Continued From page 24</p> <p>period; glucose values greater than 300 mg/dl within 2 consecutive days; or when any reading is too high based on the [resident's] normal glucose values." Initiated 6/19/17.</p> <p>Resident #7's June (No documentation provided 6/15/17 - 6/30/17 due to hospitalization) and July 2017 (7/1/17 - 7/25/17) Medication Administration Record (MAR) documented:</p> <p>June 2017 - 7:00 am * 6/2/17 - 253 * 6/4/17 - 367</p> <p>June 2017 - 5:00 pm * 6/3/17 - 296 * 6/5/17 - 285 * 6/9/17 - 271 * 6/10/17 - 279 * 6/11/17 - 281</p> <p>July 2017 - 7:00 am * 7/6/17 - 256</p> <p>July 2017 - 11:00 am * 7/6/17 - 269</p> <p>July 2017 - 4:30 pm * 7/3/17 - 259 * 7/4/17 - 284 * 7/6/17 - 288 * 7/7/17 - 289 * 7/9/17 - 273</p> <p>A Weights and Vitals Summary from 6/1/17 through 7/25/17 documented Resident #7 was assessed with a BG of 367 mg/dl on 6/4/17 and a BG of 406 mg/dl on 6/19/17.</p>	{F 309}	<p>monitored to ensure the deficient practice will not recur:</p> <p>Monitoring will be done through:</p> <p>The DON or Designee will conduct 3 random chart audits of residents who are on blood glucose monitoring to verify appropriate procedures have been followed</p> <p>Monitoring will start on 9/5/2017 This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3</p> <p>The DON or Designee will present to the quarterly QA Committee meeting any findings and/or corrective actions taken</p> <p>Compliance, continuation/discontinuation of monitoring will be discussed during the QA Committee quarterly meeting.</p> <p>9/5/2017</p>		

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{F 309}	<p>Continued From page 25</p> <p>On 7/26/17 at 5:05 pm, the Assistant Director of Nursing (ADON) stated Resident #7's clinical record did not contain documentation that the physician had been contacted per facility policy or as care planned. Physician orders did not direct staff to provide physician notification when the resident's BGs exceeded 250 mg/dl or 300 mg/dl.</p> <p>2. Resident #28 was admitted to the facility on 4/5/16 with diagnoses that included Type II diabetes mellitus.</p> <p>Physician orders, dated 5/26/17, documented staff was to provide Humalog insulin per sliding scale before meals when Resident #28's BGs exceeded 150 mg/dl as follows (all measurements in milligrams per deciliter - mg/dl):</p> <ul style="list-style-type: none"> <li>* 150 - 200: 2 units</li> <li>* 201 - 250: 4 units</li> <li>* 251 - 300: 6 units</li> <li>* 301 - 350: 8 units</li> <li>* 351 - 400: 10 units</li> </ul> <p>The 5/26/17 physician's order noted, "Call MD [physician] if greater than 400 [mg/dl] ..."</p> <p>Resident #28's Diabetes Care Plan, dated 4/18/17, documented, for BG's greater than 350 [mg/dl] and notify the physician immediately. Notify the physician as soon as possible when: Glucose values are greater than 250 mg/dl within a 24-hr [hour] period; glucose values greater than 300 mg/dl within 2 consecutive days; or when any reading is too high based on the [resident's] normal glucose values." Initiated 4/18/17.</p>	{F 309}			

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{F 309}	<p>Continued From page 26</p> <p>A Weights and Vitals Summary from 6/1/17 through 7/25/17 documented the following BG values (all measurements in mg/dl) for Resident #28:</p> <ul style="list-style-type: none"> <li>* 6/23/17 - 293</li> <li>* 6/24/17 - 262</li> <li>* 6/25/17 - 279</li> <li>* 6/29/17 - 255</li> <li>* 7/8/17 (7:24 am) - 343</li> <li>* 7/8/17 (7:25 am) - 343</li> <li>* 7/9/17 (6:43 am) - 306</li> <li>* 7/9/17 (12:12 pm) - 251</li> <li>* 7/19/17 - 259</li> </ul> <p>The facility was asked, but did not provide documentation that Resident #28's physician was notified of the above BGs per Care Plan and facility policy.</p> <p>On 7/26/17 at 5:05 pm, the Assistant Director of Nursing (ADON) stated Resident #28's clinical record did not contain documentation that the physician had been contacted per the facility's newly revised (May 2017) policy or as care planned. The ADON said the facility only followed physician orders regarding hypo/hyperglycemic physician notification and the physician orders did not direct staff to provide physician notification when the resident's BGs exceeded 250 mg/dl or 300 mg/dl.</p> <p>3. Resident #31 was admitted to the facility on 4/20/17 with a diagnosis of Type II Diabetes Mellitus. The resident discharged from the facility on 7/5/17.</p>	{F 309}			

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{F 309}	Continued From page 27  Resident #31's medication orders documented the resident received Glipizide 10 milligrams [mg] each morning for diabetes, beginning 4/21/17, and Metformin HCl 500 mg twice daily for diabetes, beginning 4/30/17. Each of these medications was documented as administered on Resident #31's MARs for June 2017, and July 1 through 5, 2017. There was no physician's order for Resident #31's blood glucose levels to be monitored, and no documentation of blood glucose levels for Resident #31.  The Wolters Kluwer 2018 Nursing Drug Handbook documented for Glipizide that fasting blood glucose levels should be monitored regularly while using that medication, and Metformin HCl required regular monitoring of blood glucose levels.  On 7/26/17 at 4:20 pm, the Assistant Director of Nursing (ADON) stated that Resident #31's blood glucose levels should have been monitored.  4. Resident # 29 was admitted to the facility on 5/19/17 with a diagnosis of Type 2 Diabetes Mellitus.  Resident # 29's physician's orders documented the resident received Lantus SoloStar Solution insulin 25 units at bedtime daily, and to monitor the resident's blood glucose at bedtime daily. The physician's orders did not document blood glucose parameters which would require interventions and/or physician notification.  Resident #29's MAR for June 2017 documented blood glucose readings between 128 mg/dl and	{F 309}			

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{F 309}	Continued From page 28 233 mg/dl. Resident # 29's MAR for July 2017 documented blood glucose levels between 98 mg/dl and 279 mg/dl.	{F 309}			
{F 323} SS=E	On 7/26/17 at 7:45 pm, the ADON stated Resident #29's physician's orders should specify parameters for notification should blood glucose readings be too high or too low. 483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  (d) Accidents. The facility must ensure that -  (1) The resident environment remains as free from accident hazards as is possible; and  (2) Each resident receives adequate supervision and assistance devices to prevent accidents.  (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.  (1) Assess the resident for risk of entrapment from bed rails prior to installation.  (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.  (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by:	{F 323}		9/5/17	

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{F 323}	<p>Continued From page 29</p> <p>Based on observation, resident and staff interview, and record review, it was determined the facility failed to ensure residents' beds equipped with siderails were safe. This was true for 6 of 6 residents reviewed for siderail use (#s 7, 8, 9, 27, 28, and 29) and all other residents in the facility using bed siderails and had the potential for harm if residents became entrapped in a siderail that had not been assessed as safe for their use. Findings include:</p> <p>From 7/25/17 through 7/26/17, Resident #s 7, 8, 9, 27, 28, and 29 were observed in their beds with bilateral "cane" siderails in the upraised position.</p> <p>On 7/26/17 at 9:05 am, Resident #7 was observed in bed with bilateral bed "cane" siderails in the upraised position. Resident #7 stated s/he used the siderails to assist him/her into- and out of bed "every day."</p> <p>On 7/26/17 at 9:15 am, Resident #27 was observed in bed watching television with bilateral bed "cane" siderails in the upraised position. Resident #27 stated s/he used the siderails to assist him/her into- and out of bed "every day."</p> <p>On 7/26/17 at 9:25 am, Resident #9 was observed in bed watching television with bilateral bed "cane" siderails" in the upraised position. Resident #9 stated s/he used the siderails to assist him/her into- and out of bed, and to "scoot (reposition) "every day."</p> <p>The clinical records of each resident contained a Risk and Benefit form for use of siderails, but did not include any evidence the assistive device had</p>	{F 323}	<p>F 323 SS=E 483.25 (d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility does ensure that resident beds equipped with side rails are assessed as safe</p> <p>Corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice</p> <p>Resident # 27 discharged from the facility Resident # 29 discharged from the facility</p> <p>Safety Assessment will be completed and or side rails will be removed for all affected residents.</p> <p>Identification of other residents having the same potential to be affected by the same practice and what corrective actions taken includes the following:</p> <p>All current and future residents who have a side rail on their bed have the potential to be affected by this deficient practice.</p> <p>All residents who are in need of a side rail will be assessed for side rail safety and proper use.</p> <p>All staff will be educated on proper side rail procedures</p> <p>Measures that will be put into place or systematic changes you will make to</p>		

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{F 323}	Continued From page 30 been assessed as safe for use by Resident #7, Resident #27, or Resident #9.  On 7/25/17 at 5:15 pm and again on 7/26/178 pm, the facility's Administrator and Assistant Director of Nursing stated the facility had not conducted safety assessments for the use of bed siderails for any resident in the facility equipped with the assistive device.  Similar findings for Resident #s 8, 28, and 29.	{F 323}	ensure that the deficient practice does not recur includes the following:  To ensure the deficient practice does not recur,  Facility has developed a new side rail safety and needs assessment that will be used to determine whether or not side rails are appropriate for each resident's unique situation.  All admissions going forward having a need or requesting side rails will have appropriate safety assessment completed  How the corrective actions will be monitored to ensure the deficient practice will not recur:  Monitoring will be done through:  Administrator or designee will conduct 3 random audits of residents that utilize bed rails to ensure the following  " Each resident with a side rail has been assessed with the newly created safety assessment " Each Resident has received the risks and benefits education " Each Resident has a signed consent form.  Monitoring will start on 9/5/2017 This will be done weekly x 4, then q 2 weeks x 4, then monthly	

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{F 323}	Continued From page 31	{F 323}	The Administrator or Designee will present to the quarterly QA Committee meeting any findings and/or corrective actions taken		
{F 328} SS=D	<p>483.25(b)(2)(f)(g)(5)(h)(i)(j) TREATMENT/CARE FOR SPECIAL NEEDS</p> <p>(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must:</p> <p>(i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and</p> <p>(ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments</p> <p>(f) Colostomy, ureterostomy, or ileostomy care. The facility must ensure that residents who require colostomy, ureterostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences.</p> <p>(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to ... prevent complications of enteral feeding</p>	{F 328}	<p>Compliance, continuation/discontinuation of monitoring will be discussed during the QA Committee quarterly meeting.</p> <p>9/5/2017</p>	9/5/17	

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{F 328}	<p>Continued From page 32 including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers.</p> <p>(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences.</p> <p>(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.</p> <p>(j) Prostheses. The facility must ensure that a resident who has a prosthesis is provided care and assistance, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, to wear and be able to use the prosthetic device. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure oxygen liter flow rates were monitored and documented, and failed to ensure physician's orders were in place for a Continuous Positive Airway Pressure (CPAP) machine. This was true for 2 of 5 residents (#s 8 and 31) sampled for respiratory care. The deficient practice created</p>	{F 328}	<p>F 328 SS=D 483.25 (b)(2)(f)(g)(5)(h)(i)(j) TREATMENT/CARE FOR SPECIAL NEEDS</p> <p>The facility does ensure all residents have individualized parameters for their Oxygen and CPAP needs according to</p>		

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{F 328}	<p>Continued From page 33</p> <p>the potential for harm if residents experienced pulmonary complications from receiving too much oxygen.</p> <p>Findings included:</p> <p>1. Resident #8 was admitted to the facility on 5/4/17 with diagnoses which included hypertension and edema.</p> <p>Resident #8's admitting physician's orders included, check O2 Sats [oxygen saturations] every shift to maintain sats [greater than] 90 %.</p> <p>The facility's physician's Standard Orders for all residents in the facility, dated 7/12/17, documented the standard application of oxygen for a resident should be 2 liters per minute.</p> <p>Resident # 8's Weights and Vitals summary sheet and Medication Administration Record for July 2017 documented oxygen saturations between 91% and 99%. Neither documented liter flow when oxygen was used.</p> <p>On 7/25/17 at 2:20 pm, Resident #8 was lying in her bed. She was not wearing an oxygen cannula.</p> <p>On 7/26/17 at 11:25 am, Resident #8 was wearing in bed, wearing an oxygen cannula with a liter flow at 2 liters per minute. Resident #8 stated she asked to wear oxygen at times when she felt she could not breathe effectively, which the resident related to her fluctuating edema levels. Resident #8 stated the facility did not routinely check her oxygen saturations before the cannula was applied, but checked them at least</p>	{F 328}	<p>their physician orders.</p> <p>Corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice</p> <p>Resident # 8 oxygen order was clarified with MD Resident # 31 no longer resides in facility</p> <p>Identification of other residents having the same potential to be affected by the same practice and what corrective actions taken includes the following:</p> <p>All residents requiring oxygen or use of CPAP have the potential to be affected by this deficient practice.</p> <p>All current and future guests that require oxygen and a CPAP will have orders in place by a Physician and clarification will be requested as needed</p> <p>All nurses shall be educated on the need to follow physician orders and to request clarification orders when indicated, and to ensure, if CPAP is in use, that current orders are in place.</p> <p>Measures that will be put into place or systematic changes you will make to ensure that the deficient practice does not recur includes the following:</p> <p>All new physician orders will be reviewed during clinical review to ensure they are complete and accurate, and those</p>		

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{F 328}	<p>Continued From page 34</p> <p>once per day. Resident #8 stated the facility had not yet checked her oxygen saturations that day.</p> <p>On 7/26/17 at 6:50 pm, the Assistant Director of Nursing (ADON) stated Resident #8's oxygen saturations should be checked both before and after application, to ensure the both the need for and effectiveness of oxygen administration. The ADON stated the liter flow of oxygen delivered should also be documented on the MAR.</p> <p>2. Resident #31 was admitted to the facility on 4/20/17 with diagnoses which included obstructive sleep apnea. Resident #31 discharged from the facility on 7/5/17.</p> <p>Resident #31's Nurse's Notes documented the resident used a CPAP (Continuous Positive Airway Pressure) machine while sleeping for his diagnosis of sleep apnea on at least 8 occasions between 5/3/17 and 6/12/17.</p> <p>Resident #31's record did not contain a physician's order for the use of a CPAP machine. There was no documentation on Resident #31's MARs or Treatment Administration Records (TARs) regarding the use of a CPAP machine. There was no documentation in Resident #31's physician's progress notes or his History and Physical that the resident required a CPAP machine.</p> <p>On 7/26/17 at 4:20 pm, the ADON stated that while Resident #31 was a resident in the facility, he used a CPAP machine he had in the community. The ADON stated the facility there should have had a physician's order and monitoring for its use.</p>	{F 328}	<p>residents that require use of CPAP have orders in place.</p> <p>How the corrective actions will be monitored to ensure the deficient practice will not recur:</p> <p>Monitoring will be done through:</p> <p>The DON or Designee will perform 3 random chart/room audits of residents who are on oxygen or CPAP orders to verify that physician orders are being followed correctly and that orders are in place</p> <p>Monitoring will start on 9/5/2017 This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3</p> <p>The DON or Designee will present to the quarterly QA Committee meeting any findings and/or corrective actions taken</p> <p>Compliance, continuation/discontinuation of monitoring will be discussed during the QA Committee quarterly meeting.</p> <p>9/5/2017</p>		

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{F 441} SS=D	<p>483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>(a) Infection prevention and control program.</p> <p>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:</p> <p>(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2);</p> <p>(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p>	{F 441}		9/5/17	

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{F 441}	Continued From page 36 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.  (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and  (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.  (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.  (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.  (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure resident's urinals were stored in a sanitary manner. This was true for 1 of 1 residents (# 29) sampled for urinal use. The deficient practice created the potential for contamination when a soiled urinal was stored on an overbed table with food and grooming items. Findings include:	{F 441}	F 441 SS=D 483.80 (a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS  The facility does ensure that resident urinals are stored in a sanitary manner  Corrective action(s) will be accomplished		

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{F 441}	<p>Continued From page 37</p> <p>Resident #8 was admitted to the facility on 5/19/17 following a total knee replacement.</p> <p>Resident #8's 60 day MDS assessment dated 7/14/17 documented the resident was occasionally incontinent of urine.</p> <p>Resident #8's care plan, initiated 5/19/17, documented the resident needed assistance with toileting in the morning, before and after meals, at bedtime, and twice during the night. There was no documentation on the care plan regarding the use of a urinal.</p> <p>On 7/25/17 at 1:00 pm, Resident #8 was sitting in his wheelchair in his room. A urinal with approximately 1 inch of yellow liquid inside was on the overbed table. The urinal was dated "7/16" with a blue felt pen. The overbed table also contained an open can of Glucerna with a straw, a water mug, two packages of Teddy Grahams, a sandwich bag full of candy bars, an electric razor, three containers of lotion, a nail file, and an ace wrap. Regarding the urinal, Resident #8 stated, "I don't know why that's there. It's just what they give me when I tell them I have to go."</p> <p>On 7/25/17 at 1:20 pm, LN #2 stated the urinal should not be on the overbed table with the other items, but there was nothing the facility could do to prevent it since Resident #8 did not put on his call light to alert staff it was there. LN #2 emptied the urinal. LN #2 stated it must be Resident #8's preference to use the urinal, rather than have staff assist him to use the toilet. LN #2 left the razor, nail file, food, liquids, and lotion all on the table.</p>	{F 441}	<p>for those residents found to have been affected by this deficient practice</p> <p>Resident #29 no longer resides in facility</p> <p>Identification of other residents having the same potential to be affected by the same practice and what corrective actions taken includes the following:</p> <p>All residents have the potential to be affected by this deficient practice.</p> <p>All staff shall be educated on need to follow standards of practice that ensures the proper sanitation and storage of urinals</p> <p>Measures that will be put into place or systematic changes you will make to ensure that the deficient practice does not recur includes the following:</p> <p>To ensure the deficient practice does not recur,</p> <p>Facility shall institute resident room audits that will specifically address the need to verify that urinals are not stored on bed side tables or other areas that could potentially cause an infection control violation. In addition urinals will be inspected to verify that residue is not left in the container and that it is cleaned appropriately</p> <p>All staff upon hire shall be educated on the need to follow infection control</p>		

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{F 441}	<p>Continued From page 38</p> <p>On 7/26/17 at 10:30 am, the Administrator was informed of the above observation and staff response. The Administrator stated Resident #8 should be offered the toilet before the urinal, and if he chose to use the urinal, staff should empty it right away and not leave it on the overbed table.</p> <p>On 7/26/17 at 1:25 pm, a urinal was observed on Resident #8's overbed table. The urinal was empty, but contained a thick yellow residue at the bottom. The urinal was dated "7/16" in a blue felt pen. The overbed table also contained a partial bowl of chili, an open can of Glucerna with a straw, an open plastic cup with approximately 4 ounces of milky brown liquid with a straw, a water mug, one package of Teddy Grahams, a salt and pepper shaker, a container of alcohol-based hand sanitizer, six snack-sized candy bars, an electric razor, and 3 containers of lotion.</p> <p>On 7/26/17 at 1:30 pm, CNA #1 stated the urinal should not be on the table, and moved it so it was hooked on the side rail of Resident #8's bed. CNA #1 stated, "I'm sorry you had to see that." CNA #1 left the remaining items on the overbed table.</p>	{F 441}	<p>procedures that includes a description on proper urinal storage and sanitation.</p> <p>How the corrective actions will be monitored to ensure the deficient practice will not recur:</p> <p>Monitoring will be though:</p> <p>The Administrator or Designee will review 3 random room audits to verify that urinal storage and sanitation portion is completed. If issues are noted corrections must be addressed.</p> <p>Monitoring will start on 9/5/2017 This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3</p> <p>The Administrator or Designee will present to the quarterly QA Committee meeting any findings and/or corrective actions taken</p> <p>Compliance, continuation/discontinuation of monitoring will be discussed during the QA Committee quarterly meeting.</p> <p>9/5/2017</p>		
{F 520} SS=F	<p>483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>(g) Quality assessment and assurance.</p> <p>(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of:</p>	{F 520}		9/5/17	



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NAME OF PROVIDER OR SUPPLIER  <b>MADISON CARRIAGE COVE SHORT STAY REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>410 WEST 1ST NORTH</b> <b>REXBURG, ID 83440</b>		
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{F 520}	<p>Continued From page 40</p> <p>determined the facility's Quality Assurance (QA) program failed to thoroughly evaluate and sufficiently monitor facility care processes to ensure previously identified deficient practices did not recur. These failed practices:</p> <p>a) Placed any resident admitted to the facility at risk of violations of their resident rights;</p> <p>b) Placed Resident #31 at risk of not receiving medications as ordered;</p> <p>c) Placed Resident #s 30 and 31 at risk of not having information at the time of discharge to ensure continuity of care;</p> <p>d) Placed Resident #s 7, 28, 29, 31, and any other diabetic residents in the facility of not having their diabetes managed effectively;</p> <p>e) Placed Resident #s 7, 8, 9, 27, 28, and 29, as well as any other resident in the facility using side rails, at risk of injury or entrapment when safety assessments were not completed;</p> <p>f) Placed Resident #s 8 and 31 at risk of pulmonary injury when treatment for respiratory issues was not monitored; and</p> <p>Findings included:</p> <p>1. The facility was found out of compliance during their recertification and complaint survey on 4/21/17 for not fully informing residents of their rights at the time of admission, and cited at F 156. The facility alleged they were in compliance with this requirement as of 5/31/17.</p>	{F 520}	<p>QUARTERLY/PLANS</p> <p>The facility does ensure that its QA program thoroughly evaluates and sufficiently monitors facility care processes to ensure that previous deficient practices do not recur</p> <p>Corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice</p> <p>All staff shall be reeducated on the QA process.</p> <p>QA meeting and processes were reevaluated and it was decided that the facility will hold a monthly QA meeting until such time it is unnecessary</p> <p>Identification of other residents having the same potential to be affected by the same practice and what corrective actions taken includes the following:</p> <p>All residents have the potential to be affected by this deficient practice.</p> <p>QA meeting and processes were reevaluated and it was decided that the facility will hold a monthly QA meeting until such time it is unnecessary</p> <p>Measures that will be put into place or systematic changes you will make to ensure that the deficient practice does not recur includes the following:</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135140</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R</b> <b>07/26/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>MADISON CARRIAGE COVE SHORT STAY REHABILITATION</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>410 WEST 1ST NORTH</b> <b>REXBURG, ID 83440</b>		
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{F 520}	<p>Continued From page 41</p> <p>On 7/25/17 at 5:15 pm, the Administrator stated the facility had corrected the specific items in the Admission Agreement identified as deficient during the 4/21/17 survey, and had presented those corrections to the QA committee. However, the Administrator stated the facility had neither read the regulatory requirement or reviewed the rest of the Admission agreement prior to alleging substantial compliance with the requirement.</p> <p>2. The facility was found out of compliance during their recertification and complaint survey on 4/21/17 for failure to administer medications per physician's order, and cited at F 281. The facility alleged compliance with this regulatory requirement on 5/31/17.</p> <p>On 7/26/17 at 4:20 pm, the Assistant Director of Nursing (ADON) stated the facility had been monitoring the medications with the same classification as identified as deficient in the 4/21/17 survey, but had not expanded their monitoring to include other types of medications.</p> <p>3. The facility was found out of compliance during their recertification and complaint survey on 4/21/17 for failure to complete a discharge summary for residents returning to the community, and cited at F 283. The facility alleged substantial compliance with this requirement as of 5/31/17.</p> <p>On 7/26/17 at 4:20 pm, the ADON stated she thought the facility was back in compliance, as they now made sure discharging residents had a list of the medications they were receiving upon discharge. The ADON stated she did not believe anyone at the facility had reviewed the entire</p>	{F 520}	<p>To ensure the deficient practice does not recur,</p> <p>QA meeting will be held monthly until the facility determines that it has sufficiently corrected deficient standards and practices. At that time the QA committee shall determine if monthly QA meetings will be moved to quarterly.</p> <p>QA committee shall establish subcommittees that will be tasked with specific areas of care and processes that they will each individually report on.</p> <p>Minute notes shall be kept to ensure that things discussed shall be preserved for the review and follow up on assignments and goals of the committee.</p> <p>All required members shall be present at each QA meeting</p> <p>How the corrective actions will be monitored to ensure the deficient practice will not recur:</p> <p>Monitoring will be done through:</p> <p>The Governing Body representative or Designee will review QA minute notes and agenda to verify that action items are being accomplished, survey readiness is being discussed and all required members are present.</p> <p>Monitoring will start on 9/5/2017 This will be done monthly until if and</p>	

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{F 520}	<p>Continued From page 42</p> <p>regulatory requirement when developing, implementing, and monitoring the plan of correction.</p> <p>4. The facility was found to be out of compliance with diabetic management during their recertification and complaint survey on 4/21/17, and cited at F 309. The facility alleged substantial compliance with this requirement as of 5/31/17 and failed to follow the revised policy and procedure developed.</p> <p>The ADON stated the facility thought they were in compliance with the regulatory. The ADON was unable to explain how the facility was monitoring, evaluating, and revising their diabetic management process as part of the QA process.</p> <p>5. The facility was found to be out of compliance with the regulatory requirement for side rail safety assessments during the recertification and complaint survey on 4/21/17, and cited at F 323. The facility alleged substantial compliance with this requirement on 5/31/17. On 7/25/17 at 5:15 pm, the ADON stated the facility had implemented a new side rail assessment that included documentation regarding the resident's cognitive ability, and as such were able to determine the safety of the devices. The Administrator stated the facility did not have an updated policy, and was unsure what standard of practice the facility used as the basis for their new assessment.</p> <p>6. The facility was found to be out of compliance with the regulatory requirement for oxygen administration during the recertification and complaint survey on 4/21/17, and cited at F 358.</p>	{F 520}	<p>when meetings are moved to quarterly at which time it will be conducted quarterly.</p> <p>The Governing Body Representative or Designee will present to the quarterly QA Committee meeting any findings and/or corrective actions taken</p> <p>Compliance, continuation/discontinuation of monitoring will be discussed during the QA Committee quarterly meeting.</p> <p>9/5/2017</p>		

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{F 520}	<p>Continued From page 43</p> <p>The basis for the citation was the lack of liter flow specified when oxygen was administered.</p> <p>On 7/26/17 at 4:20 pm, the ADON stated once the facility fixed the problem identified by the survey team in April, they monitored their compliance with that component of oxygen management but did not consider other aspects of respiratory care.</p> <p>On 7/26/17 at 5:15 pm, the Administrator stated he had not yet been employed at the facility at the time the 4/21/17 survey took place, or when the facility's plan of correction was submitted. The Administrator stated there had been one QA meeting that had taken place since he started at the facility was on 6/28/17, and focused on how the implementation of the plan of correction was progressing. The Administrator stated the 6/28/17 QA meeting discussion also included the facility's QA process as it lacked a clearly defined structure and methodology. The Administrator stated that he had not read the regulatory requirements as they pertained to the deficiencies cited on survey, but only the findings in the survey report the facility received.</p>	{F 520}			

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001445</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>07/26/2017</b>
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NAME OF PROVIDER OR SUPPLIER  <b>MADISON CARRIAGE COVE SHORT STAY RE-</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>410 WEST 1ST NORTH</b> <b>REXBURG, ID 83440</b>
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{C 000}	<p><b>16.03.02 INITIAL COMMENTS</b></p> <p>On September 26, 2017, an off-site follow-up of the facility was conducted to verify correction of deficiencies noted during the survey of July 26, 2017. Madison Carriage Cove was determined to be in compliance with state health care requirements as of September 5, 2017..</p> <p>The surveyors conducting the survey were:</p> <p>David Scott, RN, Team Coordinator Nina Sanderson, LSW</p>	{C 000}		
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Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  Electronically Signed	TITLE	(X6) DATE <b>08/15/17</b>
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