



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor  
RUSS 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)

October 3, 2017

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

Provider #: 135007

Dear Mr. Teckmeyer:

On **September 21, 2017**, a survey was conducted at Bingham Memorial Skilled Nursing & Rehabilitation by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be an isolated deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

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

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **October 13, 2017**. Failure to submit an acceptable PoC by **October 13, 2017**, may result in the imposition of penalties by **November 5, 2017**.

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

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

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

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

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

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **October 26, 2017 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **December 20, 2017**. A change in the seriousness of the deficiencies on **November 5, 2017**, may

Mark Teckmeyer, Administrator  
October 3, 2017  
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result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **December 20, 2017** includes the following:

Denial of payment for new admissions effective **December 20, 2017**. [42 CFR §488.417(a)]

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

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **March 20, 2018**, if substantial compliance is not achieved by that time.

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

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

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **December 20, 2017** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

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

Mark Teckmeyer, Administrator  
October 3, 2017  
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<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:

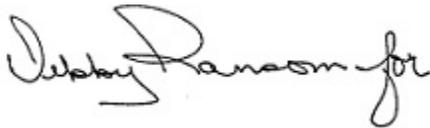
- BFS Letters (06/30/11)

2001-10 Long Term Care Informal Dispute Resolution Process  
2001-10 IDR Request Form

This request must be received by **October 13, 2017**. If your request for informal dispute resolution is received after **October 13, 2017**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,



Nina Sanderson, LSW, Supervisor  
Long Term Care

ns/lj  
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135007</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/21/2017</b>
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NAME OF PROVIDER OR SUPPLIER  <b>BINGHAM MEMORIAL SKILLED NURSING &amp; REHABILITATION</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>98 POPLAR STREET BLACKFOOT, ID 83221</b>
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(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
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F 000	INITIAL COMMENTS  The following deficiencies were cited during the federal recertification survey conducted at the facility from September 18, 2017 through September 21, 2017.  The surveyors conducting the survey were: Edith Cecil, RN, Team Coordinator Beverly Briggs, RN Stephen Burgin, RN  Survey Abbreviations:  CNA = Certified Nurses Aide DON = Director of Nursing LPN = Licensed Practical Nurse MDS = Minimum Data Set PT = Physical Therapist	F 000		
F 311 SS=D	483.24(a)(1) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS  (a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, and medical record review, it was determined the facility failed to provide a restorative nursing program for 1 of 7 residents (Resident #5) sampled for restorative nursing programs. The deficient practice created the potential for harm if the resident experienced a functional decline when restorative services were not provided. Findings include:	F 311	*CORRECTIVE ACTIONS FOR RESIDENT SPECIFIC: ¿ Resident # 5 was affected by this deficient practice. - The restorative plan created by the therapy department for resident #5 was reviewed and verified with his restorative flow sheet to be accurate. A restorative care plan was made for the resident to reflect the current plan of care.	10/26/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <b>Electronically Signed</b>	TITLE	(X6) DATE <b>10/12/2017</b>
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 311	<p>Continued From page 1</p> <p>Resident #5 was admitted to the facility on 3/20/17 with diagnoses including a cerebrovascular accident (stroke), congestive heart failure, and shoulder pain.</p> <p>Resident #5's most recent quarterly Minimum Data Set (MDS) assessment, dated 7/22/17, documented the resident had moderate cognitive impairment, was dependent on two staff for bed mobility and transfers, and had limited use of his left arm and leg.</p> <p>Resident # 5's Activities of Daily Living care plan, dated 7/22/17, did not document the resident had a restorative nursing program, and no updates to add a restorative nursing program were documented.</p> <p>Resident #5's "Physical Therapy Discharge Summary," dated 7/30/17, documented recommendations for restorative nursing services for strengthening and standing. The summary documented the resident's anticipated outcome was "good with consistent staff follow through."</p> <p>On 9/19/17 at 9:15 am Resident #5 stated that he was told that "the State" said that he was no longer progressing and no longer eligible physical therapy, so he would be transferred to a restorative nursing program. Resident #5 stated it had been almost two months since his physical therapy ended, but he had not yet had any restorative nursing services. He stated he felt he may have lost some strength in his left leg by not being in a restorative program.</p> <p>On 9/19/17 at 10:10 am, Physical Therapist (PT) #2 stated she remembered Resident #5 and</p>	F 311	<p>*CORRECTIVE ACTION FOR POTENTIAL RESIDENTS THAT MAY BE AFFECTED BY THIS DEFICIENT PRACTICE :</p> <p>-Residents who are not currently receiving skilled therapy services has the potential to be affected by this deficient practice. Non skilled residents has been evaluated by the IDT to review the presence of a restorative program. The restorative flow sheet, restorative plan of care created by therapy and the restorative care plan has been reviewed by the IDT to ensure accuracy and appropriateness of the program for the resident.</p> <p>*MEASURES(FACILITY SYSTEMS) THAT WILL BE PUT IN PLACE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR:</p> <p>-The Restorative Nursing policy for BMH SNRC has been updated to reflect the procedure when transitioning a discharged skilled resident into restorative nursing services.</p> <p>-The therapy department, restorative nursing assistant and the MDS nurse has been educated regarding the procedure .This is to ensure that a restorative plan of care will be initiated as recommended.</p> <p>-The IDT will audit residents who are discharged from skilled therapy to validate that a restorative plan of care was made and initiated.</p>		

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F 311	Continued From page 2 wrote a Restorative Plan for him as part of his discharge from skilled therapy 8/3/17. PT #2 stated she provided the Restorative Plan to the Director of Nursing (DON), as the DON oversaw the Restorative Nursing Program. She stated that she did not get any feedback on the Restorative Plan or told why it was not implemented.  On 9/19/17 at 4:30 pm, CNA #1 stated she was the Restorative CNA, but was not aware of any restorative program for Resident #5 prior to 9/19/17, but had received a program that day. CNA #1 stated that Resident #5's spouse had inquired about when the resident's restorative program was going to start about a week and a half ago, and CNA #1 had asked the DON about it, but had not received a response "until today."  On 9/21/17 at 10:00 am PT #2 stated she re-evaluated the resident on 9/19/17 and did not believe the resident lost any strength or function since his discharge from physical therapy.  On 9/19/17 at 4:35 pm the DON stated she could not find the Restorative Plan from 8/3/17. The DON stated if she had received a restorative referral from physical therapy she would have processed it the same day.	F 311	A.WHO: - The DNS or designee - B.FREQUENCY: - will audit 3x a week for 1month , then 2x/week for 1 month ,weekly x 1 month for a period of 12 weeks .Any issue noted will be immediately addressed. The QA committee will review any issues uncovered by the weekly audits and after the initial 12 weeks make a determination related to changing the frequency of those audits. C.START DATE: -October 16,2017 *DATES WHEN CORRECTIVE ACTION IS COMPLETED: -October 26,2017		
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS  (a) Infection prevention and control program.  The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:  (1) A system for preventing, identifying, reporting,	F 441		10/26/17	

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F 441	<p>Continued From page 3</p> <p>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> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable</p>	F 441			

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F 441	<p>Continued From page 4</p> <p>disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and</p> <p>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>(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, staff interview and policy review, it was determined the facility failed to ensure hand hygiene occurred for 1 of 10 residents (#5) observed for hand hygiene. The deficient practice created the potential for harm if the resident developed infection from unsanitary practices. Findings include:</p> <p>On 9/19/17 at 3:15 pm, during suprapubic catheter care for Resident #5, LPN #1 washed her hands, placed the supplies on the over bed table, and put on a pair of gloves. LPN #1 removed the soiled dressing that covered the ostomy (surgically created opening between an internal organ and the body surface), then removed her gloves and replaced them with a new pair of gloves. LPN #1 did not wash her hands or use hand sanitizer between glove</p>	F 441	<p>*CORRECTIVE ACTIONS FOR RESIDENT SPECIFIC:                  ☞ Resident #5 was affected by this deficient practice.                  ☞ License Nurse #1 was educated on Handwashing, Hand Antisepsis and Surgical Hand scrub, Reference #921 facility policy</p> <p>*CORRECTIVE ACTION FOR POTENTIAL RESIDENTS THAT MAY BE AFFECTED BY THIS DEFICIENT PRACTICE :                  -The residents with foley /suprapubic catheter has the potential of being affected by this deficient practice.                  -The IDT will audit targeted residents to</p>		

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F 441	<p>Continued From page 5</p> <p>changes. LPN #1 cleaned the ostomy with sterile normal saline solution and then applied a clean dressing. LPN #1 then repositioned Resident #5 and removed her gloves. Following the dressing change, LPN #1 walked to the sink and washed her hands.</p> <p>On 9/19/17 at 3:30 pm, LPN #1 stated she forgot to sanitize her hands between glove changes.</p> <p>The facility Policy and Procedure titled "Handwashing, Hand Antisepsis and Surgical Hand Scrub," Reference #921, Version 9 with an effective date of 6/30/17 documented, "Hand hygiene must be performed at a minimum upon arrival to the facility, before and after touching each patient, before clean/aseptic procedures, after body fluid exposure, putting on gloves (clean or sterile), and after removing gloves, after touching anything in the patient's environment, before and after eating, after using the restroom, and when hands are visible soiled."</p> <p>On 9/19/17 at 4:10 p.m. the Director of Nursing (DON) stated it was facility policy that hand hygiene must be performed anytime gloves were removed. The DON stated that LPN #1 not sanitizing her hands after removing soiled gloves and replacing them with clean gloves was not following facility infection control policy.</p>	F 441	<p>evaluate if License Nurses are following facility handwashing policy during a catheter care nursing procedure.</p> <p><b>*MEASURES(FACILITY SYSTEMS) THAT WILL BE PUT IN PLACE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR:</b></p> <p>-The License Nurses has been in serviced regarding the facility handwashing policy. -The License Nurses will be audited during cares to ensure compliance.</p> <p><b>*MONITORING</b> A.WHO: -The DNS or Designee B.FREQUENCY: - will audit 3x a week for 1month , then 2x/week for 1 month ,weekly x 1 month for a period of 12 weeks .Any issue noted will be immediately addressed. The QA committee will review any issues uncovered by the weekly audits and after the initial 12 weeks make a determination related to changing the frequency of those audits.</p> <p>C.START DATE: - October 16,2017 <b>* DATES WHEN CORRECTIVE ACTION IS COMPLETED:</b> - October 26,2017</p>		



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December 22, 2017

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

Provider #: 135007

Dear Mr.. Teckmeyer:

On **September 21, 2017**, an unannounced on-site complaint survey was conducted at Bingham Memorial Skilled Nursing & Rehabilitation. The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00007592**

**ALLEGATION #1:**

The facility failed to meet residents sanitary needs in a timely manner.

**FINDINGS #1:**

The allegation of the facility failing to address urinary and fecal incontinence in a timely manner could not be substantiated. There was insufficient evidence to establish that the facility acted inappropriately in response to incidents of incontinence.

An onsite investigation was conducted from September 18, 2017 through September 21, 2017. Numerous observations of toileting assistance and incontinence care were made throughout the facility and included the identified resident. Interviews were conducted with residents, their family members, and staff. A group interview was conducted with seven residents, and Resident Council minutes for the previous six months were reviewed. A review of the facility staffing records for 7/27/17 was completed and facility grievance reports from April to September 2017 were reviewed.

The investigation revealed no evidence of residents, including the identified resident, being left in soiled briefs. There were no lingering unpleasant odors in any of the resident use areas of the facility or complaints from residents of lingering foul odors.

This allegation was not substantiated for lack of evidence.

**CONCLUSIONS:**

Unsubstantiated. Lack of sufficient evidence.

**ALLEGATION #2:**

The facility failed to ensure physical therapy services were provided in a timely manner.

**FINDINGS #2:**

Numerous observations were made throughout the facility, including the provision of physical therapy and restorative nursing services to residents. Interviews were conducted with residents, family members, and staff. A group interview was conducted with seven residents, Resident Council Minutes for the previous six months were reviewed, and the facility's grievance reports from April to September 2017 were reviewed. The identified resident's clinical record, including therapy assessments and notes, was also reviewed.

The investigation revealed the identified resident was assessed by physical therapists on June 17, 2016, Physical Therapy was initiated on this date, and discontinued on August 2, 2016. The resident met her therapy goals and then began restorative therapy. The resident's abilities were maintained and no issues with the provision of physical therapy were identified for any other residents.

The allegation that the facility failed to provide physical therapy in a timely manner could not be substantiated for lack of evidence.

**CONCLUSIONS:**

Unsubstantiated. Lack of sufficient evidence.

**ALLEGATION #3:**

The facility failed to ensure medications were administered as prescribed.

FINDINGS #3:

Based on observation, interview, and record review, it was determined there were no issues identified with the timely administration- or omission of medication administration to the identified resident. The identified resident's laboratory tests due to medications were completed per physician order. Eight other residents whose clinical records reviewed as part of the complaint investigation were also without any identified concerns. No errors were noted during medication pass to residents and the pharmacy provided necessary medications to residents within the same day they were ordered.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

The facility failed to ensure adequate staffing was provided to meet residents' needs.

FINDINGS #4:

The allegation of the facility failing to provide adequate staffing on 7/26/17 at 8:00 a.m. could not be substantiated. There was insufficient evidence to establish that the facility acted inappropriately in response to the subject of the allegation and no deficiencies were written.

Three investigators conducted an onsite investigation from 9/18/17 - 9/21/17. Ten residents were reviewed in the survey sample. Numerous observations were made throughout the facility, including the provision of care to 36 residents residing in the facility during the survey. Interviews were conducted with residents, staff members (including nurses) and family members. A resident group interview was conducted with seven residents. Resident Council Minutes for the previous 6 months were reviewed. Facility grievance reports for the past six months (April to September 2017) were reviewed. The staffing logs for 7/26/17 were reviewed. An identified resident's medical record was reviewed.

The investigation revealed no lack of staffing to meet the needs of the 36 residents in the facility, including the identified resident on 7/26/17 and afterward. The facility did not have any aides in the 70-year-old age range with the name identified in the complaint who worked on 7/26/17. Staffing on 7/26/17 in the morning was adequate with three CNAs, one Registered Nurse and one Licensed Practical Nurse for a census of 42; the staffing met the State Ratios at 3.14. Staffing was adequate during the survey; residents did not express concerns with staffing.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #5:

The facility failed to ensure resident's activities of daily living (ADL) needs were met.

FINDINGS #5:

An on-site investigation conducted from September 18, 2017 through September 21, 2017 included a clinical record review for ten residents and numerous resident care observations, including cares provided to the identified resident. Interviews were conducted with residents, family members, and staff. A group interview was conducted with seven residents, including four of whom were totally dependent on staff for transfers. Resident Council Minutes and the facility's Grievance file for the previous six months (April to September 2017) were reviewed. . A review of the facility's Incident and Accident logs from April to September of 2017 was also completed.

The investigation revealed the identified resident experienced a recent decline in condition, was placed on palliative care, and primarily stayed in bed. Two staff assisted the identified resident with cares per care plan. Other dependent residents who were also observed receiving appropriate care per physician order and care plan stated staff performed transfers appropriately using the correct equipment and adequate number of staff.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #6:

The facility failed to ensure residents were provided with a clean and sanitary environment.

FINDINGS #6:

The allegation that the facility failed to provide a clean and sanitary environment to an identified resident and/or provide timely incontinence care could not be substantiated for lack of evidence.

Numerous observations throughout the facility of incontinence care, cleanliness of linens and the presence of odors identified no concerns. Interviews were conducted with residents, family members, and staff, as well as a review of the facility's Resident Council Minutes and grievance reports from April to September 2017 did not identify any issues of concern. Residents attending

a group interview did not voice concerns regarding the environment.

The investigation revealed there no evidence of the identified resident, or other residents, being left in soiled briefs; there were no lingering or unpleasant odors; soiled linens were addressed in a timely manner, and residents were observed receiving cares in a timely manner.

**CONCLUSIONS:**

Unsubstantiated. Lack of sufficient evidence.

**ALLEGATION #7:**

The facility failed to ensure residents were bathed regularly.

**FINDINGS #7:**

The identified resident was observed to be without odor, her hair was combed and clean, and her clothing was clean. There was no evidence of a lack of personal hygiene or a lack of the provision of showers/bathing. Two staff assisted the identified resident with cares. The identified resident often refused showers, and this was addressed in the care plan. In addition, no concerns with personal hygiene and bathing were noted for other residents.

Based on observation, interview, and record review, this allegation could not be substantiated for lack of evidence.

**CONCLUSIONS:**

Unsubstantiated. Lack of sufficient evidence.

**ALLEGATION #8:**

The facility failed to ensure residents were transferred from wheelchairs in a timely manner.

**FINDINGS #8:**

The investigation revealed no evidence the identified resident, or other residents, were left unattended in wheelchairs for extended periods of time. The identified resident experienced a recent decline in condition, received palliative care, and primarily stayed in bed. The resident had previously preferred to stay in a wheelchair, but had become unstable and currently remained in bed continuously per her choice. A review of wound records showed no increase in pressure ulcers that would be indicative of being left without repositioning for long periods of time.

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Based on observation, interview, and record review, this allegation could not be substantiated for lack of evidence.

**CONCLUSIONS:**

Unsubstantiated. Lack of sufficient evidence.

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

Sincerely,

A handwritten signature in cursive script that reads "Nina Sanderson (L.S.W.)". The signature is written in dark ink and is positioned above the typed name.

Nina Sanderson, L.S.W., Supervisor  
Long Term Care

NS/lj