



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

October 24, 2017

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

Provider #: 135140

Dear Mr. Bowman:

On **October 5, 2017**, a survey was conducted at Madison Carriage Cove Short Stay Rehabilitation by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be one that comprises a pattern 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

Josh Bowman, Administrator
October 24, 2017
Page 2

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 **November 3, 2017**. Failure to submit an acceptable PoC by **November 3, 2017**, may result in the imposition of penalties by **November 28, 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 **November 9, 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 **January 3, 2018**. A change in the seriousness of the deficiencies on **November 19, 2017**, may result in a change in the remedy.

Josh Bowman, Administrator
October 24, 2017
Page 3

The remedy, which will be recommended if substantial compliance has not been achieved by **January 3, 2018** includes the following:

Denial of payment for new admissions effective **January 3, 2018**. [42 CFR §488.417(a)]

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

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **April 3, 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 **January 3, 2018** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

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

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

Josh Bowman, Administrator
October 24, 2017
Page 4

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 **November 3, 2017**. If your request for informal dispute resolution is received after **November 3, 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,

A handwritten signature in black ink that reads "D. Scott". The signature is written in a cursive style with a large initial "D" and a smaller "Scott" following it.

David Scott, RN, Supervisor
Long Term Care

DS/lj

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135140	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/05/2017
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NAME OF PROVIDER OR SUPPLIER MADISON CARRIAGE COVE SHORT STAY REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 410 WEST 1ST NORTH REXBURG, ID 83440
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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	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during a complaint investigation survey conducted at the facility from October 2, 2017 through October 5, 2017.</p> <p>The survey team members were: Linda Kelly, RN, Team Coordinator Brad Perry, LSW</p> <p>Abbreviations include:</p> <p>AIT = Administrator in Training DNR = Do Not resuscitate IDON = Interim Director of Nursing IV = intravenous MDS = Minimum Data Set LPN = Licensed Practical Nurse POST = Physician Orders for Scope of Treatment</p>	F 000		
F 155 SS=D	<p>483.10(c)(6)(8)(g)(12), 483.24(a)(3) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES</p> <p>483.10 (c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.</p> <p>(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).</p>	F 155		11/6/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 11/03/2017
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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 155	<p>Continued From page 1</p> <p>(i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.</p> <p>(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.</p> <p>(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law.</p> <p>(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.</p> <p>483.24 (a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced</p>	F 155			

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F 155	<p>Continued From page 2</p> <p>by:</p> <p>Based on record review and staff interview, it was determined the facility failed to ensure a change to an Idaho Physician Orders for Scope of Treatment (POST) regarding intravenous (IV) fluids was clarified for 1 of 8 residents (#6) reviewed for Advanced Directives. The failure created the potential for harm if residents' wishes regarding IV fluids were not honored. Findings include:</p> <p>Resident #6 was admitted to the facility on 7/19/17 with multiple diagnoses, including peripheral vascular disease, chronic non-pressure ulcer of the left heel and mid foot, edema, right leg below the knee amputation, Type II diabetes mellitus, polyneuropathy, and major depressive disorder. The resident was transferred to a hospital on 8/30/17 for surgical amputation of the left leg above the knee and revision of the right leg stump. The resident was readmitted to the facility on 9/7/17.</p> <p>An 8/1/17 admission MDS (Minimum Data Set) assessment documented Resident #6 had severe cognitive impairment, but was able to express ideas/wants and understand verbal content, had continuous inattention and disorganized thinking with fluctuations in levels of consciousness, and experienced delusions.</p> <p>A 5-Day MDS assessment, dated 9/13/17, differed from the 8/1/17 assessment in that the resident was usually able to express ideas/want and disorganized thinking fluctuated.</p> <p>The resident's clinical record contained a 7/19/17 "Nurse Check-in Checklist" which documented</p>	F 155	<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 155 SS=D 483.10 (c) (6) (8) (g) (12), 483.24 (a) (3) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES</p> <p>The facility does ensure that advance directives are correct and clarified as needed.</p> <p>Corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice</p> <p>Resident # 6 has discharged</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>		

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F 155	<p>Continued From page 3</p> <p>advanced directives were in place and identified the resident's code status as DNR (do not resuscitate).</p> <p>The clinical record also contained an Idaho POST form signed by Resident #6 and a physician on 3/1/17, which documented the following:</p> <ul style="list-style-type: none"> * DNR - Allow natural death, no cardiopulmonary resuscitation or advanced cardiac life support interventions. * Artificial Fluids and Nutrition - Feeding tube was marked "Yes." IV fluids was marked "Yes." However, IV fluids was also marked "No" but the mark was scribbled over. The scribbled mark was not dated or initialed/signed. The date of the change from "No" to "Yes" for IV fluids, and who made the change, was unknown. * Antibiotics and blood products - Antibiotics was marked "Yes." Blood products was marked "No." <p>On 10/3/17 at 3:00 pm, the Medical Records staff member said the 3/1/17 Idaho POST "carried over" from Resident #6's first admission (7/19/17) to the resident's second admission (9/7/17).</p> <p>On 10/5/17 at 10:40 am, the Interim Director of Nursing (IDON) said the discrepancy on Resident #6's Idaho POST regarding IV fluids should have been clarified. The IDON said she spoke with the resident's representative at one point and the representative was "okay" with IV fluids. The IDON did not remember if she documented the conversation and did not provide documentation of a conversation with the resident's representative regarding IV fluids.</p>	F 155	<p>All current and future residents have the potential to be affected by this deficient practice.</p> <p>All resident advanced directives have been reviewed and clarified as needed.</p> <p>All resident care plans have been reviewed and clarified as needed to reflect resident wishes in regards to their advance directives.</p> <p>Education has been provided to licensed nurses and social worker on the need to obtain accurate, clear and concise Advanced Directives for each resident.</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>The admission process will be revised to ensure that resident Advanced Directives are received and revised as necessary upon admission.</p> <p>All licensed nurses and social workers will be educated upon hire on the need to follow advance directives.</p> <p>How the corrective actions will be monitored to ensure the deficient practice will not recur:</p>		

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F 155	Continued From page 4 On 10/5/17 at 10:45 am, the Administrator in Training (AIT) reviewed Resident #6's 3/1/17 Idaho POST and said the resident's wishes regarding IV fluids were not clear. The clinical record documented that IV fluids were administered to Resident #6 once on 9/12/17 and twice on 9/14/17. Without clarification regarding the resident's wishes regarding IV fluids, it was unclear whether the resident wanted IV fluids to be administered.	F 155	Monitoring will be done through: The Administrator or Designee will conduct 3 random audits of Advanced Directives and care plans to ensure that they reflect the wishes of the resident and that they are clear and concise. Monitoring will start on 11/6/2017 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. 11/6/2017		
F 205 SS=D	483.15(d)(1)(i)-(iv)(2) NOTICE OF BED-HOLD POLICY BEFORE/UPON TRANSFR (d) Notice of bed-hold policy and return- (1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;	F 205		11/6/17	

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F 205	<p>Continued From page 5</p> <p>(ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;</p> <p>(iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (c)(5) of this section, permitting a resident to return; and</p> <p>(iv) The information specified in paragraph (c)(5) of this section.</p> <p>(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (e)(1) of this section.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to provide written notice of its policy for bed-hold and return to the facility to residents or their responsible party in advance of a transfer, at the time of transfer to a hospital, or for therapeutic leave. This was true for 1 of 1 resident (#6) reviewed for transfer to a hospital. The failure created the potential for emotional distress when the resident's return to the facility was delayed. Findings include:</p> <p>Resident #6 was admitted to the facility on 7/19/17 with multiple diagnoses, including chronic non-pressure ulcer of the left heel and mid foot, right leg below the knee amputation, Type II diabetes mellitus, and major depressive disorder. The resident was transferred to a</p>	F 205	<p>F 205 SS=D 483.15 (d) (1) (i) <input type="checkbox"/> (iv)(2) NOTICE OF BED-HOLD POLICY BEFORE/UPON TRANSFER</p> <p>The facility does ensure that the written bed-hold notice is provided to resident or responsible party in advance of a transfer, at the time of transfer to a hospital, or for a therapeutic leave.</p> <p>Corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice</p> <p>Resident #6 no longer resides in facility</p> <p>Identification of other residents having the</p>		

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F 205	<p>Continued From page 6</p> <p>hospital on 8/30/17 for surgical amputation of the left leg above the knee and revision of the right leg stump. The resident was readmitted to the facility on 9/7/17, then discharged 9/16/17.</p> <p>The clinical record of the resident's first stay in the facility (7/19/17 to 8/30/17) did not contain documentation that the resident/responsible party was provided notice of the facility's bed-hold policy and return to the facility.</p> <p>The clinical record regarding the resident's second stay in the facility (9/7/17 to 9/16/17) contained a notice regarding the facility's bed-hold policy and return to the facility. The undated notice was signed by the resident's responsible party.</p> <p>On 10/5/17 at 8:20 am, the Administrator in Training (AIT) said he "thought" the responsible party was given the notice of the policy for bed-hold and return to the facility at the beginning of Resident #6's first admission (7/19/17). The AIT said he was "not aware" the bed-hold/return to facility policy was "revisited" with the responsible party when the resident transferred to the hospital on 8/30/17. The AIT said he and the Administrator visited the resident's responsible party during the resident's hospital stay. The Interim Director of Nursing (IDON) joined the conversation at 8:30 am and said initial plans for providing daily hyperbaric treatments in another town upon discharge from the hospital changed and the hyperbaric treatments were completed before the resident left the hospital. The AIT said the resident's return to the facility was delayed "one day" because they were not as familiar with bed-hold</p>	F 205	<p>same potential to be affected by the same practice and what corrective actions taken includes the following:</p> <p>All residents that transfer have the potential to be affected by this deficient practice.</p> <p>All licensed nurses and Social Worker were educated on the need to provide bed hold policy upon transfer or on next business day by the social worker/designee in the event of an emergent transfer.</p> <p>Bed hold policy was revised to reflect current standards of practice.</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>A designated location shall be established for the retrieval of the bed hold policy and instructions for use.</p> <p>All licensed nurses and social workers shall be educated upon hire on the need to provide bed hold agreement upon transfer.</p> <p>How the corrective actions will be monitored to ensure the deficient practice will not recur:</p>		

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F 205	Continued From page 7 regulations as they should have been.	F 205	Monitoring will be done through: The Administrator or Designee will conduct 3 random audits of resident transfers to ensure that the bed hold policy was given to the resident upon transfer. Monitoring will start on 11/6/2017 This will be done weekly x4, then q2 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 206 SS=E	483.15(e)(1)(2) POLICY TO PERMIT READMISSION BEYOND BED-HOLD (e)(1) Permitting residents to return to facility. A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following. (i) A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident-	F 206		11/6/17	

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F 206	Continued From page 8 (A) Requires the services provided by the facility; and (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services. (ii) If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges. (e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there. This REQUIREMENT is not met as evidenced by: Based on policy review, it was determined the facility failed to ensure its policy for return to the facility after a hospitalization or therapeutic leave included the number of bed-hold days permitted. The failure affected 1 of 1 resident (#6) reviewed for transfer to a hospital and had the potential to affect other residents who may require hospitalization or therapeutic leave. The lacking information created the potential for residents to experience emotional distress if they did not know or have information about their rights. Findings include:	F 206	F 206 SS=E 483.15(e) (1) (2) POLICY TO PERMIT READMISSION BEYOND BED-HOLD The facility does ensure that the bed hold policy indicates the amount of days allowed for a bed hold. Corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice		

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F 206	Continued From page 9 A "Healthcare Bed-Hold Policy" provided by the facility did not identify the number of days allowed for a resident to request a bed hold should a hospitalization or therapeutic leave become necessary. On 10/5/17 at 8:20 am, the Administrator in Training (AIT) said he did not know the number of days allowed for bed-hold and the number of days for bed-hold was not included in the facility's policy for bed-hold and return to the facility.	F 206	Resident #6 has discharged 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 that transfer have the potential to be affected by this deficient practice. The bed hold policy has been revised to indicate the amount of days allowed for a bed hold. 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: The bed hold policy has been revised to indicate the amount of days allowed for a bed hold. How the corrective actions will be monitored to ensure the deficient practice will not recur: Monitoring will be done through: The Administrator or Designee will conduct 3 random audits of resident transfers to ensure that the correct bed hold policy is being used. Monitoring will start on 11/6/2017 This will be done weekly x 4, then q 2		

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F 206	Continued From page 10	F 206	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 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and review of Medication Error Reports, it was determined the facility failed to ensure physician orders for wound care and medications were followed. This was true for 1 of 8 residents (#6). Failure to provide wound care as ordered created the potential for delayed healing or worsening of wounds; failure to administer an antidiarrheal medication as ordered created the potential for the resident to experience discomfort, dehydration and skin breakdown from unrelieved diarrhea. Findings include: Resident #6 was admitted to the facility on 7/19/17 with multiple diagnoses, including chronic non-pressure ulcers, right leg below the	F 281	F 281 SS=D 483.21 (b) (3) (i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The facility does ensure that physician orders are being followed as directed. Corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice Resident #6 has discharged Identification of other residents having the same potential to be affected by the same	11/6/17	

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F 281	<p>Continued From page 11</p> <p>knee amputation, Type II diabetes mellitus, and major depressive disorder. The resident was transferred to a hospital on 8/30/17 for surgical amputation of the left leg above the knee and revision of the right leg stump. The resident was readmitted to the facility on 9/7/17 and discharged on 9/16/17.</p> <p>a. Resident #6's 8/1/17 admission Minimum Data Set (MDS) documented severe cognitive impairment; extensive assistance with all activities of daily living, except eating; and 5 non-pressure ulcers.</p> <p>The resident's Skin Integrity Care Plan, initiated 7/19/17, documented "actual" skin impairments related to arterial ulcers to the left 1st and 2nd toes, left midfoot, left dorsal foot, and left heel, and a surgical wound to the right leg stump. Interventions included treatments and dressings as ordered.</p> <p>Resident #6's Order Summary Report, dated 7/1/17 to 8/31/17, contained numerous wound care/dressing change orders for each of the left foot ulcers. The orders were in place on 7/19/17 and orders to change the frequency of the wound care/dressings were dated 7/20/17, 7/27/17, 8/3/17, and 8/10/17.</p> <p>An 8/16/17 Progress Note documented, "On 8/14/17 LPN [licensed practical nurse] changed [Resident #6's] bandages on her left foot and right stump. LPN followed the orders on the top of [the resident's] wound care box assuming the orders were correct. LPN will make sure that the orders on the MAR are the ones that are used."</p>	F 281	<p>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 licensed nurses were educated on the requirement to follow physician orders.</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>All new orders shall be reviewed for accuracy in our clinical meeting.</p> <p>Random resident MAR's and TAR's shall be reviewed to ensure licensed nurses are following physician orders.</p> <p>Clinical meeting will now review all PRN medications administered within the last 7 days to ensure orders are being followed as directed.</p> <p>All new orders will be reviewed during the clinical meeting to ensure completeness and accuracy.</p> <p>All licensed nurses shall be educated upon hire on the necessity to follow physician orders.</p> <p>How the corrective actions will be</p>		

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F 281	<p>Continued From page 12</p> <p>An 8/16/17 Medication Discrepancy Report documented a nurse "did not follow [physician] orders ... the error was found out when [Resident #6] went to wound care ... on 8/15/17." Measures taken to prevent recurrence included, "Make sure I use the orders on the MAR not the ones on the wound care box."</p> <p>On 10/5/17 at 8:40 am, the Interim Director of Nursing (IDON) said the resident's wound care frequency changed often and was revised by the wound clinic to daily care on 8/15/17. The IDON said the error was found one day after it was made and the nurse who made the error was counseled.</p> <p>b. The 9/13/17 5-day MDS assessment documented Resident #6 had severe cognitive impairment, but was usually able to express ideas/wants; required extensive assistance with bed mobility, transfers, dressing, toileting, and personal hygiene; and was always incontinent of bowel.</p> <p>A Toileting Care Plan, initiated 9/7/17, documented Resident #6 was incontinent and required assistance with toileting. Interventions included changing pads; brief changes as soon as possible when soiled; peri-care as needed; and hourly toileting during the day, twice at night, and as needed.</p> <p>A 9/7/17 to 9/16/17 Order Summary Report included the antidiarrheal medications: * Imodium A-D, 2 tablets after the 3rd loose stool then 1 tablet after each unformed stool, not to exceed 6 tablets in 24 hours. Staff were to contact the physician if the resident's diarrhea</p>	F 281	<p>monitored to ensure the deficient practice will not recur:</p> <p>Monitoring will be done through:</p> <p>The Director of Nursing or Designee will conduct 3 random audits of resident charts to ensure all doctor's orders are being followed.</p> <p>Monitoring will start on 11/6/2017 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>11/6/2017</p>		

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F 281	<p>Continued From page 13</p> <p>persisted. The Imodium A-D was ordered 9/9/17. * Lomotil, as needed for diarrhea, ordered 9/14/17.</p> <p>Progress Notes, dated 9/7/17 to 9/16/17, documented the following: * 9/10/17 at 8:16 am - The first Imodium A-D tablets were administered for "3 loose stools so far this am." * 9/10/17 at 11:12 am - Imodium A-D was "ineffective" and there was "2 more loose stools." (There was no evidence another dose of Imodium A-D was administered.) * 9/11/17 at 1:30 pm - Imodium A-D tablets administered for "loose stools." * 9/11/17 at 4:25 pm - Effectiveness of Imodium A-D "Unknown." * 9/11/17 at 7:23 pm - Imodium A-D administered for "diarrhea." * 9/11/17 at 8:43 pm - "[Resident #6] has diarrhea." * 9/12/17 at 12:15 am - Imodium A-D "Effective." * 9/12/17 at 10:00 am - "Diarrhea soaking completely into briefs." (There was no documentation that Imodium A-D was administered or the physician notified.) * 9/13/17 at 11:49 pm - Two episodes of diarrhea, Imodium administered. (The Imodium A-D was not documented in the MAR on this date, nor was the efficacy of the medication monitored/documented.) * 9/14/17 at 5:48 pm - One loose BM (bowel movement). There was no documentation that Imodium A-D or Lomotil was administered. * 9/14/17 at 10:56 pm - Lomotil administered for diarrhea. * 9/15/17 at 2:27 am - Lomotil "Ineffective."</p>	F 281			

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F 281	<p>Continued From page 14</p> <p>Bowel elimination records documented Resident #6 had loose/diarrhea stools twice a day from 9/8/17 to 9/15/17.</p> <p>The resident's September 2017 Medication Administration Record documented Imodium A-D was administered 3 times: 9/10/17 at 8:16 am; 9/11/17 at 1:30 pm and 7:23 pm; and Lomotil was administered just once: on 9/14/17 at 10:56 pm.</p> <p>On 10/5/17 at 8:40 am, the Interim Director of Nursing (IDON) said Resident #6 had loose stools/diarrhea "since admit." The IDON said the facility had standing orders for antidiarrheal medications but none were started for Resident #6 before 9/10/17. The IDON said the antidiarrheal medications could have been administered more often to help control the resident's loose stools/diarrhea.</p>	F 281			



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

October 27, 2017

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

Provider #: 135140

Dear Mr. Bowman:

On **October 5, 2017**, an unannounced on-site complaint survey was conducted at Madison Carriage Cove Short Stay Rehabilitation. The complaint was investigated during an on-site Complaint Survey conducted October 2, 2017 through October 5, 2017.

Surveyors observed residents for transfers, fall precautions, and signs/symptoms of pain.

The clinical records of the identified resident and five other residents' clinical records were reviewed for Quality of Care concerns. The facility's Grievance File, as well as its Incident and Accident reports were also reviewed.

Several residents, residents' family members, CNAs, nurses, and Therapy staff were interviewed regarding various Quality of Care concerns. The Administrator in Training, the Interim Director of Nursing, the Director of Therapy, and the Medical Director were each interviewed regarding various issues.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007636

ALLEGATION #1:

The Reporting Party said an identified resident was dropped by facility staff four times during a transfer, which caused extreme pain and a broken back. The facility failed to investigate the incident and failed to notify the physician of the alleged incident.

FINDINGS:

The identified resident was no longer residing in the facility at the time the complaint was investigated.

Several staff-assisted transfers of residents were observed to be safe and adequate fall precautions were in place.

The clinical record of the identified resident included a grievance report regarding an alleged fall investigation, which included, x-ray reports, nursing, therapy, social services, and physician notes, however there were no indications the alleged fall actually took place. Five other residents' records were reviewed for accidents and falls and no concerns were identified. The facility's Incident and Accident reports were reviewed and physicians were notified immediately following any incident or fall.

Several residents and their family members said there were no concerns regarding falls or improper transfers by staff. Several Certified Nurses Assistants, nurses, and therapy staff said they did not recall the alleged incident, nor did the identified resident voice concerns regarding an incident during his/her stay. They also stated that anytime there was a transfer where a resident fell, it would be reported and investigated. The Director of Therapy said he had worked with the identified resident and although the resident expressed anxiety of falling, the resident did not tell him of the alleged incident, which he/she had only heard about from the Administrator the day before the resident discharged from the facility. The Medical Director said he was always called when any resident fell while unattended or during a staff-assisted transfer. The Administrator in Training said the identified resident did not alert the facility until just prior to discharge regarding the alleged incident and at that time the facility did a full investigation, but could not determine an improper transfer occurred during the resident's stay.

Based on observation, record review, resident, residents' family and staff interviews, it was determined the allegation could not be substantiated.

ALLEGATION #2:

An improper transfer hurt the resident and the pain continued without adequate relief.

Josh Bowman, Administrator
October 27, 2017
Page 3

FINDINGS:

Residents were observed for signs and symptoms of pain throughout the survey and no concerns were identified.

The clinical records of the identified resident and five other residents' clinical records were reviewed for pain management and no concerns were identified.

Several residents and residents' family members said there were no concerns regarding pain management, staff monitored pain, and gave pain medication in a timely manner. Several Certified Nurses Assistants, nurses, and therapy staff said they monitored residents for pain and pain was quickly addressed through pharmacological and non-pharmacological approaches. The Director of Therapy said he had worked with the identified resident and that the resident's pain was well managed. The Director of Nursing said residents' pain was well managed, especially since the facility specialized in post-surgery care, where pain management was extremely critical.

Based on observation, record review, and interviews with residents, their family members, and staff, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

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

Sincerely,

 for David Scott

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

DS/lj