IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RUSSELL S. BARRON– Director

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
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BUREAU OF FACILITY STANDARDS
3232 Elder Street
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September 28, 2018

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

Provider #: 135138

Dear Mr. Kemmerer:

On **September 14, 2018**, a survey was conducted at Teton Post Acute Care & Rehabilitation by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be an isolated deficiency that constitutes actual harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

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

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **October 8, 2018**. Failure to submit an acceptable PoC by **October 8, 2018**, may result in the imposition of civil monetary penalties by **October 31, 2018**.

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*.

This agency is required to notify CMS Region X of the results of this survey. We are recommending that CMS impose the following remedy(ies):

- **Civil Monetary Penalty**

- **Denial of payment for new admissions effective December 14, 2018**

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **March 14, 2019**, 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 Debby Ransom, RN, RHIT, Bureau

Chief, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 5; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

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

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

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

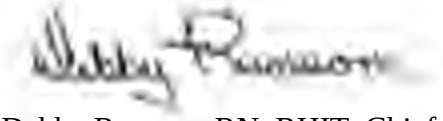
- BFS Letters (06/30/11)

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

This request must be received by **October 8, 2018**. If your request for informal dispute resolution is received after **October 8, 2018**, 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 Debby Ransom, RN, RHIT, Bureau Chief at (208) 334-6626, option 5.

Sincerely,



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

DR/lj

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135138		C 09/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TETON POST ACUTE CARE & REHABILITATION	3111 CHANNING WAY IDAHO FALLS, ID 83404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following deficiencies were cited during an unannounced complaint investigation survey conducted at the facility from September 10, 2018 to September 14, 2018. The surveyors conducting the survey were: Linda Kelly, RN, Team Leadr Susan Devereaux, RN Abbreviations: ADL = Activitiy(ies) of Daily Living cm = centimeters CNA = Certified Nursing Assistant DNS = Director of Nursing Services LPN = Licensed Practical Nurse MDS = Minimum Data Set mL = milliLiter RN = Registered Nurse	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, and staff interview, it was determined the facility failed to ensure the call light was accessible for 1 of 5 residents (Resident #3) reviewed for call lights. The failure created the potential for harm if the	F 558	F558 Corrective Action: A second call light was added to Resident #3□s room and secured in such a manner that the resident can reach it when she is in her	10/8/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Electronically Signed — 10/08/2018

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 558	Continued From page 1 resident could not summon assistance when needed or experienced an adverse medical event that required prompt attention. Findings include: On 9/10/18 at 4:20 PM, during an initial tour of resident rooms, a handwritten note was observed on the wall in Resident #3's room. The handwritten note stated, "Please Ladies, put the damn call light on my bed after making - Do you get it now?" The call light was not on Resident #3's made bed. On 9/11/18 at 11:40 AM, Resident #3, who was in her room, stated she had put the handwritten sign on the wall about 6 months ago and the call light was frequently not accessible. Resident #3's call light was observed tucked into the handhold (a hole) in the headboard on the her bed. However, the head of the bed was raised which made the call light inaccessible. On 9/11/18 at 3:50 PM, Resident #3's call light was observed hanging down by the bed frame at the head of the bed. On 9/11/18 at 4:05 PM, RN #1 accompanied the surveyor into Resident #3's room. RN #1 stated she had not seen the handwritten note about the call light on the wall previously. RN #1 looked for Resident #3's call light. RN #1 walked to the near side of the bed, then to the opposite side of the bed, then back to the near side of the bed, then back again to the opposite side of the bed. She bent down and looked under Resident #3's bed and stated the call light had fallen to the floor and was caught. RN #1 stated Resident #3 would not be able to get to the call light.	F 558	wheelchair. The call light on the bed rail was repositioned and secured in such a manner that she can reach it when in bed. Identification of others: An audit of all resident rooms will be conducted by the DNS or designee no later than 10/5/18 to validate that all residents who can utilize a call light have one positioned in a location that is accessible for them. Systematic Changes: An in-service will be conducted by the Staff Development Coordinator on or before 10/5/18. The in-service will educate staff on the importance of having a call light accessible for the residents, appropriate securement of call lights when residents are in bed, and appropriate placement of call lights so that residents can utilize them when they are out of bed. Monitor: An audit tool will be developed by the DNS or designee no later than 10/8/18. The tool will be utilized to conduct comprehensive call light placement checks within the facility. Facility-wide call light audits will be conducted twice daily at varying times for 2 weeks and then once daily x 2 weeks to validate that call lights are be placed correctly. After 4 weeks, the need for continuing auditing of call light placement will be re-evaluated.	

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F 558	Continued From page 2 On 9/13/18 at 5:30 PM, Resident #3 was observed in her room and the call light was at the head of the bed by the bed frame. Resident #3 tried to reach the call light but was unable to do so. On 9/13/18 at 5:52 PM, LPN #2 accompanied the surveyor to Resident #3's room. The LPN stated the call light was not within Resident #3's reach. On 9/13/18 at 12:54 PM, the DNS stated her expectation was call lights were accessible to residents "at all times."	F 558		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 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 practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, record review, and policy review, it was determined the facility failed to ensure residents' urinary catheters were secured to the body to avoid tugging and pulling at the insertion site, the physician orders for the size of the catheter were followed, and resulting skin tears and related skin breakdown were comprehensively and routinely assessed. This was true for 1 of 2 residents (Resident #5) reviewed who had a urinary catheter. Resident #5 was harmed when he	F 684	F684 Corrective Action: An appropriate catheter securement device has been placed on Resident #1 to help keep the catheter in place. A review was conducted on 9/26/2018 to validate that the current catheter in use matches the physician□s orders, that the skin and wound sheets are current and complete, and that the resident□s skin and elimination care	10/8/18

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F 684	Continued From page 3 developed a skin tear with full skin thickness loss to the underside of the head of his penis at the urethral opening and experienced ongoing pain related to the indwelling urinary catheter and tear. Findings include: The facility's Skin Integrity policy, updated March 2018, documented the procedure for skin impairment identified after a resident's admission included notification to the physician and resident representative, implementation of new interventions, weekly evaluation by facility clinicians. The policy also stated significant abrasions and bruises, which included skin tears, were evaluated weekly by licensed nurses and documented in the medical record. The policy was not followed. Resident #5 was admitted to the facility on 5/18/18, with multiple diagnoses including spastic quadriplegia (muscle stiffness which affects the entire body). An 8/25/18, quarterly MDS assessment documented Resident #5's cognition was intact; he required extensive assistance with bed mobility, transfers, and toileting; he had functional limitation in range of motion in both upper and both lower extremities; and an indwelling urinary catheter was in use. A nurse's note, dated 6/12/18 at 11:30 PM, documented Resident #5 had a size 16 French Foley catheter placed to check for residual urine (the amount of urine in the bladder after urination). The note documented the catheter was left in place.	F 684	plans are accurate and thorough. Identification of Others: As this deficiency has the potential to affect all residents who have indwelling catheters, an audit will be completed by the DNS or designee no later than 10/5/18 to validate that the catheter in use matches the physician orders, that an appropriate securement device is in place, and that the elimination or catheter care plans are accurate and complete. Systematic Changes: An in-service for nursing staff was conducted by the Staff Development Coordinator on or before 10/5/2018. The in-service included a review of the policy governing catheter care, transcription of orders, application of catheter securement devices, and documentation related to indwelling catheter usage. Monitoring: Beginning 10/8/18, an audit of all residents with indwelling catheters will be conducted by the DNS or designee to validate that the care plan is current and being followed, that the securement devices are being utilized correctly, and that any skin impairment resulting from catheter usage is addressed appropriately and immediately. The audit will be conducted daily x 2 weeks and then weekly x 4 weeks, at which time the need for continued auditing will be reviewed and determined by the Interdisciplinary team.	

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F 684	Continued From page 4 A physician telephone order, dated 6/13/18, stated Resident #5 was to have a #16 French Foley catheter for a neurogenic bladder (lack of bladder control due to spinal cord or nerve problem). The order stated the catheter was to be changed every 6 weeks and as needed if it failed. There were no nurse's notes in Resident #5's record from 8/2/18 to 8/14/18, 12 days. A nurse's note, dated 8/15/18 at 11:30 PM, documented Resident #5 had a 2 cm tear at the meatus (urethral opening) of his penis. The note documented Resident #5 did not complain of pain from the tear. A physician telephone order, dated 8/16/18, included DermaPhor moisture barrier 3 times a day to the tear until it healed. Resident #5's care plan was updated on 8/16/18 to address the tear at the meatus of his penis. Interventions included: moisture barrier cream to meatus 3 times a day and to encourage Resident #5 not to manipulate his urinary catheter or his penis. Nurse's notes, dated 8/18/18 and 8/19/18, documented Resident #5 complained of a burning sensation to his penis. A nurse's note, dated 8/21/18, documented Resident #5 had increased pain and burning to penis with further tearing. The nurse documented Dermaphor was applied and Resident #5 was educated not to tug at the catheter.	F 684		

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F 684	Continued From page 5 Resident #5's care plan identified the potential for issue related to the use of a Foley catheter related to neurogenic bladder. This was initiated on 8/29/18, 78 days after the insertion of the catheter. Interventions were to check the catheter every shift and as needed; check the tubing for kinks every shift; and monitor for and document pain and discomfort due to the catheter. A nurse's note, dated 9/2/18 at 11:20 PM, stated Resident #5 was pulling at the catheter and had a small amount of bleeding. The nurse stated he needed a catheter securement device. A securement device assists to hold the catheter in place and prevent pulling of the tubing. On 9/5/18, a nurse stated the catheter securement device was placed, 3 days later. There was no documentation a securement device was in place prior to 9/5/18. A nurse's note, dated 9/6/18 at 10:00 PM, documented Resident #5's catheter came out. The balloon which held it in place was intact but deflated. The nurse documented a larger catheter, size 20 was inserted with no trauma and was draining urine. A size 20 catheter is larger than a size 16, which was ordered by the physician on 6/13/18. Nurse's note, dated 9/7/18 and 9/8/18, documented the securement device for the catheter was in place and urine was draining into the bag. A physician telephone order, dated 9/10/18, included a referral to a urologist (a specialist for the genitourinary system) "ASAP" for the torn	F 684		

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F 684	Continued From page 6 meatus and erosion related to the Foley catheter. Pain Management flowsheets for August 2018 and September 2018 for Resident #5 were blank. On 9/12/18, the following observations and interviews conducted: * 8:50 AM - Resident #5 was in his wheelchair by his bed watching television. He welcomed the surveyor into his room. Resident #5 said he had a urinary catheter because he could not urinate and the tape to secure the catheter kept coming off his leg and had caused a tear on his penis. He said it was painful. * 8:54 AM - CNA #5 and CNA #6 transferred Resident #5 into bed and pulled down his pants to place a bedpan under him. Loose tape was on his urinary catheter and a loose securement device was on the inside of his right thigh, which had a lot of hair. The catheter was not secured and Resident #5 said, "See it's coming loose." * 9:30 AM - When Resident #5 finished using the bedpan, LPN #6 removed the bed covers and loosened his incontinence brief. There was an approximately 3 cm wide by 3 cm long open area, or gap, at the urethral meatus at the posterior aspect of the head of the penis. The wound was bright pink without signs or symptoms of inflammation or infection. Resident #5 said the catheter had caused the wound, and his penis was very painful. A securement device was not on either of his legs and there was no tape on the catheter. As LPN #6 began to pull up the bed covers, Resident #5 asked if she was going to secure the catheter. LPN #6 said "Oh	F 684		

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F 684	Continued From page 7 yeah," and she went to get a securement device. Resident #5 said extra securement devices were in his bedside table drawer. LPN #6 got a securement device out of the drawer and applied it to a hairy area on Resident #5's right inner thigh. The securement device immediately began to loosen. LPN #6 said she would get a different type of device to secure the catheter. * 9:40 AM - LPN #6 and the surveyor exited Resident #5's room and LPN #6 said the resident had a history of putting things in his penis and tugging on the catheter. * 5:15 PM - prior to the evening meal, LPN #1 took Resident #5 to his room and attempted unsuccessfully to visualize the size of his urinary catheter while he sat in his wheelchair. LPN #1 refastened Resident #5's clothing and said she would look again for the catheter size after the evening meal. At that point, Resident #5 said the catheter securement device was not sticking. LPN #1 moved the resident out of his room without checking the securement device. * 5:30 PM - the DNS said skin assessments and monitoring of the urethral meatus wound should be documented on the TAR (treatment administration record). The DNS reviewed Resident #5's August and September 2018 TARs and said she did not see documentation the urethral meatus wound was assessed or monitored. At that time, the weekly skin assessments/evaluations and the Incident/Accident (I&A) report of the wound were requested. * 6:15 PM - LPN #1 said Resident #5 had eaten	F 684		

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F 684	Continued From page 8 and he was ready to lay down. The surveyor accompanied LPN #1 to Resident #5's room. LPN #1 visualized his catheter and said it was a size 20, not size 16, as ordered by his physician. On 9/13/18 at 8:30 AM, the DNS provided a Weekly Skin Evaluation record which documented the following: * 8/15/18 - a 2 cm full thickness skin tear to Resident #5's urethral meatus was noted. The wound bed was pink/beefy red, there was minimal serous (clear) drainage, no odor, the surrounding skin color was pink, no pain, and the surrounding tissue/wound edges were normal skin. * 8/18/18 - the wound size was unchanged, the wound bed, surrounding skin color, and surrounding tissue was normal, no drainage or odor, and no pain. * 8/20/18 - the wound size was unchanged, the wound bed was pink, beefy red, the surrounding skin color and tissue/wound edges were normal, no drainage or odor, and no pain. * On 9/2/18, 13 days later - the wound size increased to 2.5 cm, the wound bed was pink, beefy red and the surrounding skin color was pink, the surrounding tissue/wound edges were normal, there was minimal bleeding, no odor or pain. * On 9/12/18, 10 days later - the wound size increased to 3 cm, the wound bed was pink, beefy red and the surrounding skin color was pink, the surrounding tissue/wound edges were	F 684		

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F 684	Continued From page 9 normal, there was no drainage or odor and no pain. On 9/14/18 at 10:50 AM, Resident #5 said his catheter securement device "won't stay on" and "It's damn irritating." On 9/14/18 at 11:15 AM, the DNS said she did not find an I&A report regarding the 8/15/18 wound to Resident #5's penis, but an I&A should have been completed. The DNS also said Resident #5's catheter should have been secured better to prevent injury to his penis. Resident #5 was harmed when a tear resulting in full thickness skin loss developed on his penis after the facility failed to secure, or adequately secure, his indwelling urinary catheter for 3 months after the catheter was placed on 6/12/18. In addition, the wound size increased when a larger size catheter than ordered was placed and the facility did not comprehensively assess or monitor the wound at least weekly per the facility's policy.	F 684		

IDAHO DEPARTMENT OF
HEALTH & WELFARE

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DAVE JEPPESEN – Director

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April 5, 2019

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

Provider #: 135138

Dear Mr. Kemmerer:

On **September 10, 2019** through **September 14, 2018**, an unannounced on-site complaint survey was conducted at Teton Post Acute Care & Rehabilitation. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007585

ALLEGATION #1:

The facility did not monitor residents' bowel status which resulted in a resident developing a bowel obstruction and perforation.

FINDINGS #1:

The complaint was investigated during an unannounced complaint investigation survey conducted on 9/10/18 through 9/14/18.

The clinical records for fifteen residents were reviewed for bowel monitoring and management. The facility's Bowel Protocol was also reviewed, as were the grievance files, Incident and Accident reports, and Resident Council meeting minutes for the previous 14 months. Twenty-seven residents and several licensed nurses and Certified Nursing Assistants (CNAs) were interviewed.

One resident's clinical record documented she had recurrent bowel issues. Her bowel status was monitored and tracked and interventions were implemented per her physician's orders.

The facility also notified her physician and her family in a timely manner when her bowel status worsened and hospitalization was required.

The clinical records for the other fourteen residents documented their bowel activity was tracked and interventions were implemented in a timely manner according to the facility's bowel protocol and/or their physician's orders. Additionally, there were no bowel tracking or management concerns documented in Resident Council minutes or Grievances.

All of the residents interviewed said they did not have concerns about their bowels. They said the staff monitored their bowel activity and provided interventions when they were needed.

Based on the investigative findings, there was insufficient evidence to establish the facility failed to track, monitor, or intervene, when residents had bowel concerns. Deficient practice was not identified and the allegation was not substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The facility did not monitor residents on the night shift. This resulted in one resident not receiving care during the night and another resident was found deceased the next morning.

FINDINGS #2:

The clinical records for fifteen residents were reviewed. Facility Grievance files, Incident and Accident reports, abuse and neglect allegation investigations, and Resident Council minutes for the previous fourteen months were reviewed. Nurse staffing schedules and staffing records for several months were also reviewed.

Twenty-seven residents and several licensed nurses and CNAs were interviewed. The Director of Nursing Services (DNS) and the Administrator were also interviewed.

Actual nursing staff on duty was compared to the posted staffing information and daily assignments for each day of the survey. Call light response times and staff responses to residents' needs were observed throughout the survey.

One resident's Advance Directives documented he did not want to be resuscitated and his condition had been deteriorating during the night. His record documented his family and physician were aware of his condition and the night shift staff had monitored him one hour before he was found deceased the next morning just before the shift change. His death was not unexpected.

The clinical records of the other fourteen residents, including two new residents, contained documentation that they were monitored and received cares on night shifts and the weekends.

All of the residents interviewed said they received care and the staff responded to their needs, including on the night shift and weekends.

There were no Grievances, Incident/Accident reports, or Abuse/Neglect investigations related to the staff not monitoring or providing care to residents at night or on weekends.

The nurses and CNAs interviewed said the staff provided care and services for all residents on all shifts. The DNS and Administrator concurred.

The posted staffing information and daily staff assignments matched the actual nursing staff on duty.

Based on the investigative findings, the facility staff monitored and provided care and services to residents on all shifts, including the night shift and on weekends. Deficient practice was not identified and there was insufficient evidence to establish that the facility did not provide adequate care and services on all shifts. The allegation was not substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The staff performed an inappropriate transfer which resulted in the staff stepping on and injuring a resident's toes.

FINDINGS #3:

The clinical records for fifteen residents and Incident and Accident reports for the previous fourteen months were reviewed. Twenty-seven residents and several nursing staff, including nurses and CNAs were interviewed. Four CNAs were observed as they transferred two residents using a mechanical lift and two CNAs were observed as they performed one-person assisted transfers for two residents.

An Incident and Accident report for one resident documented she bumped her toes while independently propelling herself in her wheelchair. The resident said she bumped her toes herself and the staff were not involved in the injury.

Based on the investigative findings, deficient practice was not identified and the allegation was not substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

The facility lost clothing items for several residents and gave one resident's underwear to another resident.

FINDINGS #4:

Twenty-seven residents were interviewed and Grievance files and Resident Council minutes for the previous 14 months were reviewed.

Several of the residents interviewed said they had lost articles of clothing. They said the lost items were either found or the facility replaced them. They said the facility frequently found their clothing and they always replaced the items that were not found.

There was no evidence one resident's underwear was given to another resident.

The allegation was substantiated. However, deficient practice was not identified because the facility acted appropriately when they found or replaced the missing items.

CONCLUSIONS:

Substantiated. No deficiencies related to the allegation are cited.

ALLEGATION #5:

The facility was often filthy.

FINDINGS #5:

Observations of the facility environment, including resident rooms, common areas, and dining rooms, were made throughout the survey. Twenty-seven residents, several nurses and CNAs, and two housekeepers were interviewed. Grievance files and Resident Council minutes for the previous fourteen months were reviewed.

The facility was observed to be clean and orderly during all days of the unannounced survey. Trash cans in resident rooms, common areas, nursing stations, and dining rooms were observed to be empied daily. All of the residents and nursing staff interviewed said the facility was cleaned routinely and unexpected messes were quickly cleaned up. Both housekeepers said they worked hard to keep the facility clean.

There were no Grievances or Resident Council minutes about the environment not being clean.

Based on the investigative findings, deficient practice was not identified and there was insufficient evidence to substantiate the allegation.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #6:

The facility did not have adequate staffing in the housekeeping department. Only one housekeeper was on duty on weekends and that housekeeper had to clean the facility and do laundry too.

FINDINGS #6:

Twenty-seven residents, several nursing staff, two housekeepers, and the housekeeping supervisor, were interviewed. Observations of the facility environment, including resident rooms, common areas, and dining rooms, were made daily during the survey. The laundry area was also observed. Grievances, Resident Council minutes, and the housekeeping/laundry schedules for several months were reviewed.

All of the residents and nursing staff interviewed said there were no problems with housekeeping or laundry and one housekeeper on the weekend seemed to be sufficient. Both housekeepers and their supervisor said when a housekeeper called in or did not show up for work, the other staff, or he, filled the vacancy. The housekeeping supervisor said there had been some turnover in his department but the staff had stepped up and helped out.

The facility and the laundry area were observed to be clean and well maintained and there were no grievances or Resident Council minutes related to inadequate housekeeping/laundry staff.

Based on the investigative findings, deficient practice was not identified and the allegation was not substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #7:

There was inadequate nursing staff on the weekend night shift.

FINDINGS #7:

Nursing schedules and daily assignments for the previous fourteen months, including July 2017, were reviewed. Posted Nurse Staffing information was reviewed and compared to the actual direct care nursing staff on duty during the survey. Facility Grievance files, Incident and Accident reports, investigations of allegations of Abuse/Neglect, and Resident Council minutes for the previous fourteen months were reviewed. Twenty-seven residents, several nurses and CNAs, the DNS, and the Administrator were also interviewed.

The nursing schedules and daily assignment records documented essentially no change in the number of nursing staff on duty on weekend night shifts. The posted nurse staffing information reflected the actual number and discipline of the direct care nursing staff on duty during the survey.

None of the Grievance files, Incident and Accident reports, investigations of allegations of/suspected Abuse/Neglect files, or Resident Council minutes documented concerns about inadequate nursing staff on weekend night shifts.

All twenty-seven residents and all of the facility staff interviewed said there was adequate nursing staff, including on weekends and night shifts.

Based on the investigative findings, deficient practice was not identified and there was insufficient evidence to substantiate the allegation.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.
ALLEGATION #8:

The food is "terrible" on the weekends and resulted in the residents not eating the food on the weekends.

FINDINGS #8:

Twenty-seven residents were interviewed about the food. Two surveyors and the Dietary Manager conducted a test tray for food palatability and temperature for one meal service. Two meal services were observed during the survey.
Grievances, Resident Council minutes, and food menus for the previous fourteen months were reviewed.

Twenty-four residents interviewed said the food taste and temperature was almost always very good. The other three residents interviewed said the food taste and temperature was acceptable to them. The food test tray tasted good and the food temperatures were adequate.

No residents complained about the food taste or temperature during the two meal service observations.

There were no food related concerns documented in the Grievance files or Resident Council minutes.

Based on the investigative findings, deficient practice was not identified and there was not sufficient evidence to substantiate the allegation.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

One of the allegations was substantiated, but not cited. Therefore, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

If you have any questions, comments or concerns regarding this matter, please contact Laura Thompson, RN, or Belinda Day, RN, Supervisors, Long Term Care Program at (208) 334-6626, Option #2.

Sincerely,

Laura Thompson, RN, Supervisor
Long Term Care Program

LT/lj

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April 5, 2019

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

Provider #: 135138

Dear Ms. Kemmerer:

On **September 10, 2018** through **September 14, 2018**, an unannounced on-site complaint survey was conducted at Teton Post Acute Care & Rehabilitation. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007634

ALLEGATION:

The facility did not implement appropriate infection control measures related to a bedbug outbreak.

FINDINGS:

The complaint was investigated during an unannounced complaint investigation survey conducted on-site at the facility from September 10, 2018 to September 14, 2018.

The clinical records for fifteen residents were reviewed, including two residents who had isolation precautions in place. Infection control surveillance records and reports, Grievance files, Incident and Accident reports, investigations of potential abuse/neglect, and Resident Council minutes for several months were reviewed. Infection control policies and procedures related to isolation precautions and bedbug were also reviewed. Several nurses, including the Infection Control Nurse (ICN), several Certified Nursing Assistants (CNA), the Director of Nursing Services (DNS), two housekeeper/laundry staff, and the housekeeping supervisor were interviewed. Direct care staff were observed as they provided care and services for two residents with isolation precautions in place. Two housekeepers were also observed as they provided services for the two residents in isolation.

One resident's clinical record documented she was assessed to have bedbugs the day she was admitted to the facility. Her record documented isolation precautions were implemented immediately, according to facility policy, and physician ordered interventions were initiated the same day.

The ICN said the bedbugs were confined to one resident and there was no outbreak of bedbugs. The infection control surveillance records and reports supported the ICN's statements as did the interviews with the other nurses, CNAs, and the DNS.

The housekeeping supervisor said he held in-services with his staff about infection control measures, including for bedbugs, prior to the resident with bedbugs admission to the facility. Housekeeping in-service records confirmed this.

The nurses, CNAs, and housekeepers were observed to adhere to appropriate infection control practices for both of the residents in isolation precautions. In addition, appropriate signage and personal protective equipment was observed in place for both of the residents during all days of the survey.

No documented concerns about inadequate or inappropriate infection control measures were found in the facility's Grievance files, Incident and Accident reports, investigations of potential abuse/neglect, or Resident Council minutes.

Based on the investigative findings deficient practice was not identified and the allegation was not 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.

If you have any questions, comments or concerns regarding this matter, please contact Laura Thompson, RN, or Belinda Day, RN, Supervisors, Long Term Care Program at (208) 334-6626, Option #2.

Sincerely,

Laura Thompson, RN, Supervisor
Long Term Care Program

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April 8, 2019

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

Provider #: 135138

Dear Mr. Kemmerer:

On **September 10, 2018** through **September 14, 2018**, an unannounced on-site complaint survey was conducted at Teton Post Acute Care & Rehabilitation. The complaint allegations or entity-reported incidents, findings and conclusions are as follows:

Complaint #ID00007673

ALLEGATION #1:

Facility failed to ensure resident confidentiality.

FINDINGS #1:

Fifteen resident records were reviewed, observations were made, and opportunities for confidentiality were observed. Interviews were conducted with 27 residents and numerous staff members from different departments. Resident Council Minutes and Grievances were reviewed for the past 14 months.

The court-appointed guardian of one resident was interviewed and was unable to recall ever restricting family members being informed of the resident's status. A review of the resident's record and interview with nursing and social services staff did not reveal any knowledge of family not being allowed information regarding the resident. No Resident Council or Grievance issues regarding confidentiality were found.

Based on investigative findings the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The facility was not kept clean and linen was not maintained in a clean manner.

FINDINGS #2:

Fifteen residents records were reviewed, numerous observations were made throughout the facility hallways and rooms each day of the investigation. Interviews were conducted with 27 residents and staff members from different departments regarding facility cleaning practices and resident hygiene. Resident Council Minutes and Grievances were reviewed for the past 14 months and no like concerns were identified.

Upon observations, the rooms on one hall had a few droplet like stains (not feces colored.) The Maintenance Director stated he had stained the floor wax. A schedule of room floor wax stripping and re-waxing was provided. The residents in those few affected rooms did not have any complaints regarding the housekeeping and maintenance. The resident rooms were clean in appearance, linens and clothing were observed to be clean and well maintained. There were no observations of the residents in soiled clothes, or lack of hygiene. Review of the Resident Council Minutes and Grievances failed to reveal any complaints regarding soiled linens or stained/dirty floors.

Based on investigative findings the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

Facility failed to ensure resident call lights were accessible and answered in a timely manner.

FINDINGS #3:

A total of fifteen resident records were reviewed, and observations were made. Interviews were conducted with 27 residents and numerous staff members from different departments regarding call light accessibility and response times. Resident Council Minutes and Grievances were reviewed for the past 14 months.

One current resident had an inaccessible call light; however the interviews and observations with the 26 other current residents did not reveal any accessibility issues. The interviews with all 27 residents did not include complaints of long wait times. During observations of call light response times they were answered in a timely manner.

The allegation was substantiated and a deficiency was cited at F558.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #4:

Facility failed to ensure residents were provided with appropriate and indicated feeding assistance.

FINDINGS #4:

Fifteen resident records were reviewed, observations were conducted throughout the facility dining rooms and rooms during meals. Interviews were conducted with 27 residents and numerous staff members from nursing and dietary departments regarding meal assistance. Resident Council Minutes and Grievances were reviewed for the past 14 months.

Residents that required feeding assistance or encouragement to eat were provided with assistance at all meals. Interviews with the current residents did not include any complaints or issues regarding assistance with meals. An interview with one resident's guardian did not elicit any complaints regarding the resident receiving the assistance she required. A review of the Resident Council Minutes and Grievances did not identify complaints regarding residents not receiving assistance.

Based on investigative findings the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION#5:

Facility failed to ensure residents were offered appropriate activities and ensure residents were placed in appropriate settings.

FINDINGS#5:

Fifteen resident records were reviewed and observations were made throughout the facility dining rooms

and rooms during meals. Interviews were conducted with 27 residents and numerous staff members from nursing, activities, and dietary departments. Resident Council Minutes and Grievances were reviewed for the past 14 months.

Resident's activity preferences were reviewed upon admission, and the activity log for one resident documented the resident was involved in activities of different types. Observation of the facility showed adequate activity space was provided, an activity calendar was posted in all rooms and hallways, and activities were provided. Observations of the facility dining room did not reveal any resident in the dining room 45 minutes prior to meal services unless self-directed, or self-propelled into the dining room. An interview with one resident's guardian did not elicit any complaints regarding the resident's level of involvement in activities. The Resident Council Minutes and Grievances did not identify complaints regarding residents not being invited to or assisted to attend activities.

Based on investigative findings the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #6:

Facility failed to ensure nursing services staff requested and used pain medications for residents.

FINDINGS #6:

Fifteen resident records were reviewed and observations were made of two facility residents with catheters. Interviews were conducted with 27 residents and numerous staff members from nursing regarding pain management. Resident Council Minutes and Grievances were reviewed for the past 14 months.

One resident's record included a nurse's note where a family member was complaining the resident had catheter pain; the resident received a pain medication and received relief. Other nursing notes regarding pain were addressed and the follow up documented the pain medication was effective. Interviews with the 27 residents did not identify issues with residents not receiving medication or their pain was not effectively addressed.

Based on investigative findings the allegation could not be substantiated.

ALLEGATION #7:

Facility failed to ensure residents were provided adequate liquids.

FINDINGS #7:

Observations of resident rooms, with specific intent on the availability of fluids, were conducted throughout the survey. Interviews were conducted with 27 residents regarding the availability of fluids. Resident Council Minutes and Grievances were reviewed for the past 14 months.

All resident rooms were observed for the availability of water and no concerns were noted. Interviews with 27 of the residents did not reveal any issues with fluids being available and accessible to the residents. A review of the Resident Council Minutes and Grievances did not reveal any complaints regarding fluids not be available or accessible.

Based on investigative findings the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

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

If you have any questions, comments or concerns regarding this matter, please contact Laura Thompson, RN, or Belinda Day, RN, Supervisors, Long Term Care Program at (208) 334-6626, Option #2.

Sincerely,

Laura Thompson, RN, Supervisor
Long Term Care Program

LT/lj

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June 12, 2019

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

Provider #: 135138

Dear Mr. Kemmerer:

On **September 10, 2018** through **September 14, 2018**, an unannounced on-site complaint survey was conducted at Teton Post Acute Care & Rehabilitation. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007871

ALLEGATION #1:

Facility failed to ensure assessed accommodation needs were met upon admission to the facility.

FINDINGS #1:

The allegation the facility failed to provide a suitable bed causing the resident to sleep in a wheelchair for two nights was not 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.

A total of fifteen residents were reviewed in the sample. Numerous observations were made throughout the facility of all rooms and resident beds. Interviews were conducted with 27 of the 64 residents, and numerous staff members from different departments. Resident Council Minutes and Grievances were reviewed for the past 14 months.

The investigation revealed the resident was admitted to a room with an 80" bed that had an ability to extend to 84" with an additional cushion added to the mattress. This bed was sufficient for the resident's height and weight. The resident had an order for a continuous motion machine that could only be used on a flat surface, according to the therapy department interviews. Nursing documentation showed the resident was using the machine. Nursing documentation also revealed a request for a larger bed on Friday; a rental bed was ordered and delivered on Saturday.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

Facility failed to ensure resident pain medications were administered as ordered and indicated.

FINDINGS #2:

The allegation that the facility failed to provide timely pain medication was not 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.

A total of fifteen residents were reviewed in the sample. Numerous observations were made throughout the facility of all residents. Interviews were conducted with 27 of the 64 residents with specific questions related to timing of the receipt of their medications, and numerous nursing staff members from different halls and levels of responsibility. Resident Council Minutes and Grievances were reviewed for the past 14 months.

The investigation revealed the resident had orders for Norco every four hours as needed for pain and Tramadol every 12 hours as needed for pain. The Medication Administration Record revealed six doses of Norco were administered from the evening of 6/21/18 to discharge on 6/25/18. No Tramadol doses were administered. The nurse's notes did not document any pain medication requests that could not be complied with due to timing. Resident interviews did not reveal any resident that was denied timely pain medication. Nursing staff interviews did not reveal any staff member that would not address pain as soon as possible. There were no medication issues noted in the Resident Council Minutes or Grievances. There was a lack of sufficient evidence to substantiate the allegation of delayed pain management.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

Facility failed to ensure residents need for rehabilitative services were provided as ordered.

FINDINGS #3:

The allegation of the facility failing to provide therapy services was unsubstantiated. There was insufficient evidence to establish that the facility acted inappropriately in response to the subject of the allegation and no deficiencies were written.

A total of fifteen residents were reviewed in the sample. Interviews were conducted with 27 of the 64 residents with specific questions related to rehabilitation services if received, and four of the Physical and Occupational therapists. Resident Council Minutes and Grievances were reviewed for the past 14 months.

The investigation revealed the resident was admitted on 06/21/18 at 5:00 PM with physician orders for Therapy to evaluate and treat as indicated. Therapy notes revealed the resident received physical (PT) and occupational (OT) evaluations on 06/22/18 that recommended each therapy 6 days per week. The notes also revealed the resident received therapy sessions on 06/23/18 and 06/24/18, with no therapy on Sunday. Interviews with the therapy staff revealed this was a normal schedule. Interviews with other residents, review of Resident Council Minutes and Grievances did not reveal any issues with residents receiving therapy as ordered. There was insufficient evidence to substantiate the allegation of the resident not receiving therapy as ordered.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

Facility failed to ensure the served food was palatable.

FINDINGS #4:

The allegation of the facility failing to provide palatable food 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.

Numerous observations were made throughout the facility of all residents, eating in the dining room and having meal trays in their rooms. Interviews were conducted with 27 of the 64 residents with specific questions related to food quality. Resident Council Minutes and Grievances were reviewed for the past 14 months.

The investigation revealed the residents "Meal Monitor Flowsheet" that indicated two of four breakfasts were 100% consumed, a third 50% and the fourth 25% - both the third and fourth showed a refusal of any offered alternative. Two of four lunches were 100% consumed, the third at 75% and the fourth at 50% - the fourth lunch showed a refusal of any offered alternative. Dinners had three of four with 100% consumption, and the fourth was 75% consumed. Staff interviews revealed for any meal 50% or less consumed, they are to offer something else to the residents.

Residents interviewed were, for the most part, happy with the food; the occasional complaint was found to be similar to the Resident Council Minutes with occasional complaints being about certain foods (e.g. overcooked chicken) versus the food served not being good. Observation of residents during meal times revealed no complaints about the food. Comments were overheard regarding having "seconds." The allegation of the facility serving food that was not good could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #5:

Facility failed to ensure correct medications were sent for a resident transferred to another facility.

FINDINGS #5:

The allegation of the facility sending a female's medication to the transferring facility was substantiated.

Two investigators conducted an onsite investigation on 09/10/18, 09/11/18, 09/12/18, 09/13/18, and 09/14/18. A total of fifteen residents were reviewed in the sample. Interviews were conducted with 27 of the current 64 residents with specific questions related to medication receipt; numerous licensed nursing staff were also interviewed. Resident Council Minutes and Grievances were reviewed for the past 14 months for medication related complaints.

The investigation revealed a review of four discharged residents, the resident of the complaint did have a female's medication sticker on the list of discharge medications. An interview with the receiving facility confirmed the receipt (and return) of the incorrect medication in June 2018. A review of three of the most recent discharged residents did not reveal any current deficient practice of sending the incorrect resident's medication.

Although the allegation that the incorrect medication was sent upon discharge was substantiated, the facility was not cited with deficient practice because the investigation did not substantiate current deficient practice.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient 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.

If you have any questions, comments or concerns regarding this matter, please contact Laura Thompson, RN, or Belinda Day, RN, Supervisors, Long Term Care Program at (208) 334-6626, Option #2.

Sincerely,

Laura Thompson, RN, Supervisor
Long Term Care Program

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