



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  
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October 23, 2018

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

Provider #: 135140

Dear Mr. Taylor:

On **October 12, 2018**, 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 an isolated deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

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

Landon Taylor, Administrator  
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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 **November 2, 2018**. Failure to submit an acceptable PoC by **November 2, 2018**, may result in the imposition of penalties by **November 25, 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*.

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 16, 2018 (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 12, 2019**. A change in the seriousness of the deficiencies on **November 26, 2018**, may result in a change in the remedy.

Landon Taylor, Administrator  
October 23, 2018  
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The remedy, which will be recommended if substantial compliance has not been achieved by **January 12, 2019** includes the following:

Denial of payment for new admissions effective **January 12, 2019**. [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 12, 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.

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 12, 2019** 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>

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

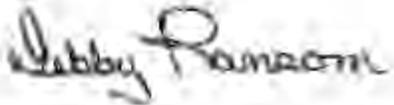
- BFS Letters (06/30/11)

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

This request must be received by **November 2, 2018**. If your request for informal dispute resolution is received after **November 2, 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:  <b>135140</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>10/12/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>MADISON CARRIAGE COVE SHORT STAY REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>410 WEST 1ST NORTH REXBURG, ID 83440</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS  The following deficiencies were cited during the federal recertification survey conducted at the facility from October 9, 2018 through October 12, 2018.  The surveyors conducting the survey were:  Linda Kelly, RN, Team Coordinator Ann Monhollen, RN  Abbreviations:  DON = Director of Nurses Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7)  §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by:  Based on observation, resident and staff interview, and clinical record and policy review, it was determined the facility failed to ensure a resident was assessed to determine if she was safe to self-administer a corticosteroid nasal spray medication. This was true for 1 of 12 sample residents (#14). The failure created the potential for adverse effects if Resident #14 self-administered fluticasone propionate inappropriately. Findings include:  The facility's Self-Administration of Medication policy, revised September 2003, documented, "A resident may not be permitted to administer or retain any medication in his/her room unless so	F 000			
F 554 SS=D		F 554	F544 Resident Self-Admin Meds-Clinically Approp Specific Resident: Resident #14 was assessed by Licensed Nurse staff to determine if self-administration of a nasal spray medication is safe and appropriate; resident #14 was identified to be unsafe to self-administrate a nasal spray medication. Nasal spray was immediately relocated to secure medication cart. Other Resident: Residents residing in the facility whom request to self-administer medication will be assessed by a Licensed Nurse per regulatory guidance; to determine if resident meets	11/7/18	

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

TITLE

(X6) DATE

Electronically Signed

10/30/2018

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 554	<p>Continued From page 1 ordered, in writing, by the attending physician."</p> <p>Resident #14 was admitted to the facility on 3/9/18 with multiple diagnoses including dementia, wheezing, and cough.</p> <p>On 10/9/18 at 3:14 PM, during an initial tour of the facility, Resident #14 was observed in her room and a container of fluticasone propionate nasal spray was on her over bed table. She said she administered the fluticasone herself once in the mornings and that she forgot to give the fluticasone back to the nurse before she left the facility that morning.</p> <p>Resident #14's quarterly Minimum Data Set (MDS) assessment, dated 9/16/18, documented cognition was intact and she was independent in all activities of daily living.</p> <p>Her care plan included impaired gas exchange related to allergies and cough, dated 3/14/18. Interventions included medications as ordered, observe for signs and symptoms of respiratory distress, and notify the physician if she had difficulty breathing, rapid breathing, rapid heart rate, or cyanosis.</p> <p>Resident #14's active physician orders documented an 8/15/18 order for fluticasone propionate 50 mcg(micrograms)/spray, one spray in each nostril in the morning for wheezing; and, a second order for fluticasone propionate suspension 50 mcg/spray, one spray in each nostril daily as needed for allergies/nasal congestion, dated 3/9/18. There were no orders for her to self-administer the fluticasone nasal spray.</p>	F 554	<p>qualifications to safely self-administer medication.</p> <p>Systemic Changes: 1) Facility Licensed Nursing staff will be educated on Self Administration of Medication Policy and Procedures. 2) Facility Licensed Nursing staff will assess residents whom request to self-administer medication per regulatory guidance.</p> <p>Monitoring: Nursing Manager or designee will conduct an audit to identify 1) if a medication is present in a resident room that has not been previously assessed for resident self-administration. 2) If medications are identified in a resident room the resident will be assessed by a Licensed Nurse for self-administration of medication per regulatory. 3) Residents who self-administrate medication will be observed during self-administration of medication to ensure appropriateness and compliance per regulatory guideline. Audit frequency will be as follows: 3x a week for 4 weeks, continuing, 2x a week for 4 weeks, continuing, 1x a week for 4 weeks.</p>		

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

PRINTED: 01/11/2019  
FORM APPROVED  
OMB NO. 0938-0391

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F 554	Continued From page 2  Her October 2018 Medication Administration Record documented both of the fluticasone orders and that the scheduled fluticasone nasal spray was administered daily in the morning from 10/1/18 to 10/11/18 and the as needed fluticasone nasal spray was not administered at all.  On 10/11/18 at 11:50 AM, the DON reviewed Resident #14's clinical record and said she did not find a self-administration assessment for the fluticasone nasal spray. The DON said Resident #14 was not assessed to self-administer the fluticasone nasal spray.	F 554			
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)  §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.  §483.45(h) Storage of Drugs and Biologicals  §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.  §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug	F 761		11/7/18	

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F 761	<p>Continued From page 3</p> <p>Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, and record and policy review, the facility failed to ensure medications were secured when they were unattended by staff. This was true for 2 of 9 residents (#2 and #20) observed during medication passes and for 1 of 12 sample residents (#14). The failure created the potential for harm if the medications were missed or taken by another resident, visitor or staff. Findings include:</p> <p>1. During a medication pass observation with Resident #2 on 10/11/18 at 11:40 AM, Registered Nurse (RN) #1 placed a medicine cup with a medication in it on the bookshelf in Resident #2's room while she assisted him in the bathroom. Then, RN #1 picked up the dirty blankets in the room and left the room, which left the medication unattended and unsecured on the bookshelf. The RN was gone approximately five minutes. When RN #1 returned, Resident #2 was still in the bathroom and not ready to take the medication. At that point, RN #1 returned the medication, in the cup, to the medication cart and moved on to another resident.</p> <p>2. During a medication pass observation with Resident #20 on 10/12/18 at 8:15 AM, Resident #20 required assistance to the bathroom prior to taking her medications. RN #1 placed the medicine cup with medications in it on Resident</p>	F 761	<p>F761 Label/Store of Drugs and Biologicals: Specific Resident: The medication for residents #2 and #20 will be stored in a locked medication cart if medication dispensed to resident is not directly received or administered by Licensed Nurse. Medication provided by Licensed Nurse to resident #2 and #20 will not be left unattended or out of direct sight. The nasal spray medication identified as unattended for resident #14 was returned to the locked medication cart for proper storage per regulatory guidelines. Other Residents: Medications provided to other residents will be stored in a locked medication cart per regulatory guidance. If medication dispensed to resident is not directly received or administered by Licensed Nurse; medication will either remain in direct sight of Licensed Nurse or will be return to locked medication cart. Systemic Changes: 1) Facility Licensed Nursing staff will be educated on appropriate handling and storage of resident medication per Policy and Procedures. 2) Facility Licensed Nursing staff will store and secure medications in a locked medication cart when not being directly administered to a resident per regulatory guidance.</p>		

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F 761	<p>Continued From page 4</p> <p>#20's over bed table then assisted her to the bathroom. RN #1 and Resident #20 were in the bathroom, with the door closed, for approximately five minutes, which left the medications unattended and unsecured. While RN #1 assisted Resident #20 in the bathroom, the Director of Nursing (DON) came into Resident #20's room. The DON saw the medicine cup with medications on the over bed table and said the medications were not secured. Then, the DON left Resident #20's room.</p> <p>On 10/12/18 at 8:45 AM, RN #1 said she did not have a reason why she left Resident #2 and Resident #20's medications unsecured, except that both of them needed assistance when she went into their rooms. The RN said she should have secured the medications when she knew they would be out of her sight.</p> <p>On 10/12/18 at 9:00 AM, the DON said the medications should not have been left unattended.</p> <p>The facility's policy for Administering Oral Medications, revised on 09/03, documented, "Steps in the Procedure ...Remain with the resident until all medications have been taken..."</p> <p>3. On 10/9/18 at 3:14 PM, during an initial tour of the facility, Resident #14 was observed in her room and a container of fluticasone propionate nasal spray was on her over bed table. She said she administered the fluticasone herself once in the mornings and that she forgot to give the fluticasone back to the nurse before she left the facility that morning.</p>	F 761	<p>Monitor: Licensed Nursing staff or designee will conduct an audit to identify if 1) a resident medication is handled and stored in a secure location by a Licensed Nurse, and 2) if resident medication is not directly received or administered, then, medication handled by Licensed Nurse is not left unattended or out of sight per regulatory guidance. Audit frequency will be as follows: 3x a week for 4 weeks, continuing, 2x a week for 4 weeks, continuing, 1x a week for 4 weeks.</p>		

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F 761	Continued From page 5 On 10/11/18 at 11:50 AM, the DON said the fluticasone nasal spray should have been secured but it was not secured when it was left in Resident #14's room.	F 761			

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001445</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/12/2018</b>
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NAME OF PROVIDER OR SUPPLIER  <b>MADISON CARRIAGE COVE SHORT STAY RE-</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>410 WEST 1ST NORTH REXBURG, ID 83440</b>
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C 000	<p><b>INITIAL COMMENTS</b></p> <p>The following deficiency was cited during a State licensure survey conducted at the facility from October 9, 2018 to October 12, 2018.</p> <p>The surveyors conducting the survey were:</p> <p>Linda Kelly, RN, Team Coordinator Ann Monhollen, RN</p>	C 000		
C 664	<p>02.150,02,a Required Members of Committee</p> <p>a. Include the facility medical director, administrator, pharmacist, dietary services supervisor, director of nursing services, housekeeping services representative, and maintenance services representative. This Rule is not met as evidenced by: Based on staff interview, review of Infection Control Committee (ICC) meeting attendance records, and policy review, it was determined the facility failed to ensure required committee members participated in Infection Control Meetings. The failure of required committee members to participate in ICC meetings created the potential for negative outcomes for residents, visitors, and staff in the facility. Findings include:</p> <p>The facility's 2005 ICC policy documented the committee "shall" include the following individuals:</p> <ul style="list-style-type: none"> <li>* Administrator, or designee;</li> <li>* Medical Director;</li> <li>* DON (Director of Nurses);</li> <li>* Infection Control Coordinator, or designee;</li> <li>* Dietitian or Food Service Director;</li> <li>* Consultant Pharmacist;</li> </ul>	C 664	<p>C664 Required Members of Committee Specific Resident: No specific resident affected. Other Residents: No other residents affected. Systemic Changes: Infection Control Committee Meetings will have required attendees: administrator, or designee; Medical Director; DON; Infection Control Coordinator, or designee; dietician or food service manager; consulting pharmacist; environmental services manager; maintenance manager; laundry manager; and others as appropriate per facility policy and regulatory guidelines. Monitor: Facility administrator or designee will audit Infection Control Committee Meeting attendees to ensure required committee members are present per facility policy and regulatory guidelines.</p>	11/7/18

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  Electronically Signed	TITLE	(X6) DATE  10/30/18
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Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001445</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/12/2018</b>
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C 664	<p>Continued From page 1</p> <ul style="list-style-type: none"> <li>* Environmental Services Director/Supervisor;</li> <li>* Maintenance Director/Supervisor;</li> <li>* Laundry Director/Supervisor; and,</li> <li>* Others as appropriate.</li> </ul> <p>On 10/11/18 at 3:40 PM, the Administrator said he did not attend ICC meetings.</p> <p>On 10/11/18 4:29 PM, Registered Nurse #1 said the DON and Assistant Director of Nurses (ADON) had been training her for one to two month to be the Infection Control Coordinator. RN #1 said she had not attended ICC meetings.</p> <p>On 10/12/18 at 10:20 AM, the DON said she, the ADON, and RN #1 shared Infection Control Coordinator duties and that RN #1 would eventually take over the coordinator role. The DON said they reviewed infection control policies annually, including the policy for the ICC. The DON said she reviewed infection control analysis information with the medical director and pharmacist monthly and the three of them met at least quarterly.</p> <p>On 10/12/18 at 10:55 AM, the DON provided attendance records for ICC meetings dated 3/28/18, 6/13/18, and 9/28/18, which documented that she, the medical director, and the pharmacist attended. The DON said the Administrator, Food Services Director, a representative from housekeeping/laundry services, and a representative from maintenance services had not been attending or participating in any of the ICC meetings.</p>	C 664	Audit frequency will be as follows: 1x a month 3 months.	
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