



IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

TAMARA PRISOCK—ADMINISTRATOR
DIVISION OF 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
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January 31, 2019

Monte Jones, Administrator
Rexburg Care & Rehabilitation Center
660 South Second Street West
Rexburg, ID 83440-2300

Provider #: 135105

Dear Mr. Jones:

On **January 9, 2019**, we conducted an on-site revisit and a complaint investigation to verify that your facility had achieved and maintained compliance. We presumed, based on your allegation of compliance, that your facility was in substantial compliance as of **November 28, 2018**. However, based on our on-site revisit we found that your facility is not in substantial compliance with the following participation requirements:

F0000 -- S/S: -- -- Initial Comments

F0684 -- S/S: D -- 483.25 -- Quality Of Care

F0689 -- S/S: D -- 483.25(d)(1)(2) -- Free Of Accident Hazards/supervision/devices

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.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **February 10, 2019**.

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

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

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

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

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

As noted in the Bureau of Facility Standards' letter of **October 26, 2018**, following the survey of **October 12, 2018**, we have already made the recommendation to the Centers for Medicare and Medicaid Services (CMS) for a civil money penalty, Denial of Payment for New Admissions and termination of the provider agreement on **April 12, 2019**, if substantial compliance is not achieved by that time. The findings of non-compliance on **January 9, 2019**, has resulted in a continuance of the remedy(ies) previously mentioned to you by the CMS. On **January 15, 2019**, CMS notified the facility of the intent to impose the following remedies:

- DPNA made on or after **January 31, 2019**

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

Monte Jones Administrator

January 31, 2019

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If you believe the 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.

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

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

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

- BFS Letters (06/30/11)

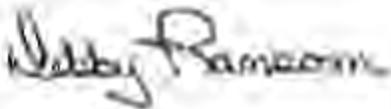
2001-10 Long Term Care Informal Dispute Resolution Process

2001-10 IDR Request Form

This request must be received by **February 10, 2019**. If your request for informal dispute resolution is received after **February 10, 2019**, 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 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

Enclosures

Monte Jones Administrator

January 31, 2019

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

PRINTED: 02/06/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135105	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 01/09/2019
NAME OF PROVIDER OR SUPPLIER REXBURG CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 660 SOUTH SECOND STREET WEST REXBURG, ID 83440		
(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 onsite revisit and complaint investigation survey conducted at the facility January 8, 2019 and January 9, 2019. The surveyors conducting the survey were: Linda Kelly, RN, Team Coordinator Wendi Gonzales, RN Survey Abbreviations: CNA = Certified Nursing Assistant DON = Director of Nursing PRN = as needed	{F 000}			
{F 684} SS=D	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 staff interview, record review, and policy and procedure review, it was determined the facility failed to ensure residents received care and treatment which met professional standards of practice for nursing. This was true for 4 of 11 residents (#10, #17, #26, and #28) whose records were reviewed. These failed practices had the potential to adversely affect or	{F 684}	1. Resident #10 discharged from Rexburg Center on 12/28/2018. Resident #17 had a pain evaluation completed by the Center Nurse Executive or designee on 1/11/2019. Follow up was completed as indicated. Resident #26 had a pain evaluation completed by the Center Nurse Executive or designee on	1/30/19	

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

TITLE

(X6) DATE

Electronically Signed

02/05/2019

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 684}	<p>Continued From page 1</p> <p>harm residents whose care and services were not delivered according to accepted standards of clinical practices. Findings include:</p> <p>1. A facility policy and procedure Tracheostomy Care, revised 12/1/18, documented, "...Suction trach, if clinically indicated (refer to Tracheostomy Suctioning procedure)..."</p> <p>The Tracheostomy Suctioning policy and procedure, revised 12/1/18, stated after suctioning a resident staff were to document the date and time of the procedure, the amount, color, and consistency of secretions, and the resident's response to suctioning.</p> <p>Resident #10 was admitted to the facility in June 2014, with multiple diagnoses including acute respiratory failure. She was readmitted in April 2016, with additional diagnoses of obstructive sleep apnea and a tracheostomy (a surgical intervention to provide air passage to help breathing).</p> <p>Resident #10's care plan documented an alteration in her health related to the tracheostomy on 10/3/14. There were multiple interventions for tracheostomy care and management, including instructions for the staff to suction her tracheostomy as ordered.</p> <p>A December 2018 Order Summary Report for Resident #10 documented multiple orders for tracheostomy care and management, including a 4/8/16 order to suction her tracheostomy prn (as needed) to manage secretions.</p> <p>Resident #10's December 2018 Treatment</p>	{F 684}	<p>1/11/2019. Follow-up was completed as indicated. Resident #28's medication administration records for the last 30 days were reviewed by the Center Nurse Executive on 1/11/2019 for incomplete documentation including refusals without follow-up. Follow-up was completed as indicated.</p> <p>2. A review of residents who required suctioning or tracheostomy care was completed by the Center Nurse Executive on 1/11/2019 and no current resident's required suctioning or tracheostomy care. A review of resident's pain medication administration record for PRN efficacy monitoring was completed by the Center Nurse Executive or designee on or before 1/30/2019. Follow-up was completed on or before 1/30/2019.</p> <p>3. Licensed nurses were re-educated on PRN medication administration requirements including medication efficacy and documentation of suctioning and tracheostomy care by the Center Nurse Executive or designee on or before 1/30/2019. Licensed nurses were re-educated on process for refusals or missing/incomplete documentation on the medication administration record by the Center Nurse Executive or designee on or before 1/30/2019. Beginning 2/1/2019 a nurse manager will review the MAR's at the end of the month for any needed follow-up related to PRN administration, refusals of medication or tracheostomy care. Beginning 1/11/2019 a nurse to</p>		

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{F 684}	<p>Continued From page 2</p> <p>Administration Record (TAR) included the order to suction her tracheostomy prn. There was no documentation Resident #10's tracheostomy was suctioned in the TAR.</p> <p>Progress Notes, dated 11/3/18 through 12/28/18, documented Resident #10 was suctioned on 12/28/18 at 4:15 AM. There were no other progress notes in Resident #10's record which documented her tracheostomy was suctioned from 11/3/18 to 12/28/18.</p> <p>On 1/8/19 at 6:20 PM, CNA #1 said she recalled Resident #10 had a tracheostomy and the nurses suctioned her sometimes.</p> <p>On 1/8/19 at 6:30 PM, LPN #1 recalled Resident #10 had a tracheostomy and said he had helped when other nurses suctioned her tracheostomy, and he had suctioned her a few times when her assigned nurse was not available.</p> <p>On 1/9/19 at 12:00 PM, CNA #2 recalled Resident #10 had a tracheostomy and said she had observed a nurse suction her once.</p> <p>On 1/9/19 at 12:45 PM, the DON reviewed Resident #10's record and said she knew the nurses suctioned Resident #10's tracheostomy every shift, "But, it's not documented."</p> <p>On 1/9/19 at 1:45 PM, RN #1 said she suctioned Resident #10's tracheostomy "usually only 1 to 2 times" every 1 to 2 weeks. RN #1 said the last time she suctioned her tracheostomy was on 12/25/18, and she documented it in the progress notes. RN #1 reviewed the progress notes for Resident #10, then said she did not document</p>	{F 684}	<p>nurse shift changes process was initiated to include a review of PRN administration to ensure complete documentation and follow-up.</p> <p>4. Beginning the week of 1/30/2019 an audit of 5 residents MARs and/or TARs will be completed by the Center Nurse Executive or designee to ensure that medications are administered as ordered, PRN efficacy monitoring is in place and suctioning tracheostomy care is completed as ordered. These audits will be completed weekly for 4 weeks then monthly for 2 months. The results of these audits will be reported to the center QAPI committee for review monthly for 3 months or until substantial compliance is achieved.</p> <p>5. The Center Nurse Executive is responsible for monitoring and follow-up. Compliance date is 1/30/2019.</p>		

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{F 684}	<p>Continued From page 3</p> <p>Resident #10's tracheostomy was suctioned on 12/25/18.</p> <p>On 1/9/19 at 2:10 PM, RN #3 said she suctioned Resident #10's tracheostomy "at least 1 time per shift, sometimes more." RN #3 said the last time she suctioned her was on 12/26/18, and she documented it in the progress notes. RN #3 reviewed Resident #10's progress notes then said she did not document she suctioned Resident #10's tracheostomy on 12/26/18.</p> <p>On 1/9/19 at 3:39 PM, with the DON present, RN #2 said it was not uncommon to suction Resident #10's tracheostomy several times a day and she routinely suctioned her when she did her tracheostomy care. RN #2 reviewed Resident #10's clinical record and said she did not document when she had suctioned the Resident #10's tracheostomy. The DON said the nurses suctioned Resident #10 but they did not document it in the record.</p> <p>2. Resident #17 was admitted to the facility in January 2017, with multiple diagnoses including dementia, anxiety disorder, recurrent major depressive disorder, generalized muscle weakness, and respiratory failure with hypoxia (diminished oxygen to body tissues).</p> <p>Resident #17's care plan, revised 2/27/18, documented she was at risk for alterations in comfort related to generalized pain. Interventions included advising her to request pain medication before the pain was severe, assisting her to reposition and use pillows as needed, provide a calm quiet area prior to medications when she was tearful, mild exercises as tolerated, and</p>	{F 684}			

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{F 684}	<p>Continued From page 4 administer pain mediations as ordered.</p> <p>Resident #17's Order Summary Report included an order, dated 1/20/17, to monitor her pain every shift.</p> <p>A Medication Administration Record (MAR) for January 2019, documented Resident #17's pain was monitored every shift except on the evening shifts on 1/2/19, 1/3/19, and 1/4/19.</p> <p>On 1/8/19 at 6:30 PM, LPN #1 said he monitored Resident #17's pain level when he was her nurse. He said he used a Faces pain scale to rate her pain if she was unable to vocalize her pain level. The Faces pain scale shows a series of faces ranging from happy to crying with numbers from 0-10, 0 or a happy face meaning no pain and 10 or a crying face meaning the worst pain.</p> <p>On 1/9/19 at 3:30 PM, RN #2 said she monitored Resident #17's pain when she cared for her and she used the Faces pain scale to rate her pain level. RN #2 reviewed the January 2019 MAR and said "some pain monitors" were not documented.</p> <p>On 1/9/19 at 3:45 PM, the DON reviewed Resident #10's January 2019 MAR and said she knew her pain was monitored every shift but the evening shift nurse did not document it on 1/2/19, 1/3/19, or 1/4/19.</p> <p>3. Resident #26 was admitted to the facility in December 2015 and readmitted on 1/16/18, with multiple diagnoses including generalized muscle weakness.</p>	{F 684}			

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{F 684}	Continued From page 5 Resident #26's record included an Order Summary Report and January 2019 MAR which documented an order, dated 9/14/18, for Tylenol 325 mg, one tablet every 4 hours as needed for pain. The MAR documented the Tylenol was administered daily on 1/1/19 through 1/5/19, three times on 1/6/19, and daily on 1/7/19, 1/8/19, and 1/9/19. A PRN Pain Management Flow Sheet attached to the January 2019 MAR in Resident #26's record documented the efficacy of the Tylenol was monitored on 1/1/9, 1/5/19, once on 1/6/19 at 9:00 PM, and on 1/9/19. There was no documentation for the two other Tylenol administrations on 1/6/19 or the one time administrations of Tylenol on 1/7/19 and 1/8/19, the pain medication was effective for Resident #26. Progress notes for Resident #26, dated 12/10/18 to 1/9/19, documented the efficacy of the prn Tylenol was monitored on 1/6/19 at 2:00 PM. However, there was no other documentation the efficacy of the Tylenol was monitored on 1/2/19, 1/3/19, 1/4/19, the third time on 1/6/19, 1/7/19, or 1/8/19. On 1/8/19 at 4:15 PM, Resident #26 said the staff "almost always" asked him about his pain level about an hour after they gave him a Tylenol. On 1/9/19 at 4:25 PM, the DON reviewed Resident #26's record and said the efficacy of his prn Tylenol was not documented for several	{F 684}			

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{F 684}	<p>Continued From page 6 days.</p> <p>4. A facility policy and procedure General Medication Administration, revised on 7/24/18, documented if a medication was refused staff were to circle their initials in the date and time space for the medication and document the resident's refusal on the back of the MAR.</p> <p>Resident #28 was admitted in July 2017, with multiple diagnoses including generalized edema and lymphedema (swelling that generally occurs in one of your arms or legs). She was readmitted on 2/1/18, with additional diagnoses including generalized muscle weakness and acquired short Achilles tendon of an ankle.</p> <p>On 1/8/19 at 9:25 AM, during a brief tour of resident rooms, Resident #28 said one nurse gave her medications "very late all the time" and that had caused her potassium medication to be missed sometimes. She said she had not reported the problem to anyone.</p> <p>Resident #28's record included an Order Summary Report which documented orders, dated 2/1/18, for acetazolamide (diuretic) 250 mg, 1 tablet by mouth 2 times a day for edema and for potassium chloride 20 mEq (miliequivalent) extended release, 1 tablet by mouth 4 times a day for hypokalemia (potassium deficiency).</p> <p>Resident #28's January 2019 MAR documented the administration times for the acetazolamide was 8:00 AM and 4:00 PM and the potassium times were 8:00 AM, 12:00 PM, 4:00 PM, and 8:00 PM daily.</p>	{F 684}			

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{F 684}	Continued From page 7 Resident #28's MAR documented a circle around a staff member's initials at the 4:00 PM administration time for the acetazolamide on 1/1/19, 1/5/19, and 1/6/19; and, at the 8:00 PM administration time for the potassium on 1/2/19. In addition, the 12:00 PM administration time for the potassium was blank on 1/1/19, 1/5/19, and 1/6/19. There was no explanation regarding the circled initials documented on the MAR. On 1/8/19 at 11:50 AM, the DON said there were no medication errors since 11/28/18. On 1/9/19 at 1:45 PM, RN #1 said she administered medications within an hour before or after the scheduled time. She said she was not aware of any medications administered late. On 1/9/19 at 2:10 PM, RN #3 said it was possible she administered Resident #28's medications late in the past, "Because she's at the end of the hall." RN #3 said she had not been Resident #28's nurse in January 2019, until today. RN #3 said Resident #28 refused her acetazolamide that morning. She pointed to the word "ref" documented on the MAR above her circled initials at the 8:00 AM time for the acetazolamide on 1/9/19, and said "ref" meant the medication was refused. On 1/9/19 at 3:30 PM, the DON reviewed Resident #28's record. She said circled initials meant a medication was not administered. She said an explanation should have been documented each time the acetazolamide and potassium administration times contained circled initials. She said there was no documented	{F 684}			

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{F 684}	Continued From page 8	{F 684}			
{F 689}	Free of Accident Hazards/Supervision/Devices SS=D CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and Incident/Accident (I&A) reports, it was determined the facility failed to ensure the correct equipment was in place as care planned for 1 of 4 residents (Resident #26) who were reviewed for falls. The failure created the potential for harm when Resident #26 experienced two unwitnessed falls. Findings include: Resident #26 was admitted to the facility in December 2015, with multiple diagnoses including fractures of the hip and right arm, heart failure, a seizure disorder, arthritis, and urinary retention. He was readmitted in January 2018, with an additional diagnosis of generalized muscle weakness. Resident #26's care plan documented he was at risk for falls related to impaired mobility, history of falls, medications, seizure disorder, and arthritis. Interventions included an anti-roll back bar to his wheelchair on 3/17/16.	{F 689}	1. Resident #26 was evaluated by the Center Nurse Executive or designee on 1/28/2019 including fall risk and care plan interventions including validation that fall prevention devices were in place at the bedside as indicated by the evaluation. 2. A review of resident's fall prevention plans was completed by the Center Nurse Executive or designee on or before 1/30/2019 to ensure that plans were based on resident assessed need and that interventions were implemented at the bedside. Follow-up was completed as indicated by the review. A center round to evaluate that devices including wheelchairs were in place per the residents plan of care was completed by the Center Nurse Executive or designee on or before 1/30/2019. Any identified concerns were completed at the time of the review.	1/30/19	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135105	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 01/09/2019
NAME OF PROVIDER OR SUPPLIER REXBURG CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 660 SOUTH SECOND STREET WEST REXBURG, ID 83440		
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{F 689}	<p>Continued From page 9</p> <p>An I&A report, dated 12/12/18, documented Resident #26's did not have the correct wheelchair when he had an unwitnessed fall at 4:15 PM. The report documented he was found on the floor next to his bed and he was not injured. The report documented Resident #26 tried to get in his wheelchair and it moved out from under him and tipped over backwards. The report concluded Resident #26 had a different wheelchair which did not have an anti-roll bar on it. The report documented his name was placed on his wheelchair to ensure he received the correct wheelchair after it was cleaned.</p> <p>A Care Team Review progress note about the 12/12/18 fall, dated 12/17/18, documented Resident #26 had an anti-roll back bar on his wheelchair but was given a wheelchair without the anti-roll back bar when the wheelchairs were taken to be washed. The progress note documented Resident #26's name was placed on the wheelchair to ensure it was returned to the correct resident after washing.</p> <p>An I&A report, dated 1/6/19, which was in progress at the time of the revisit survey, documented Resident #26 was found on the floor in front of a wheelchair next to his bed at 5:50 AM. The report documented there was no injury but Resident #26 complained his "bottom hurt."</p> <p>Progress Notes documented he complained of pain after the fall on 1/6/19, as follows:</p> <ul style="list-style-type: none"> * 1/6/19 at 2:00 PM - complaint of pain in the "buttock area;" * 1/6/19 at 10:00 PM - "...all over pain but especially in right hip." 	{F 689}	<p>3. Center nursing staff was educated by the Center Nurse Executive or designee on ensuring that fall prevention measures are implemented per the residents fall prevention plan on or before 1/30/2019. Beginning 1/11/2019 the center implemented a wheelchair labeling program, using labels that do not include resident's wheelchairs are returned to them after the cleaning process. Beginning 1/30/2019 a nurse manager will validate that residents fall prevention devices/plans are in place post-fall. Beginning 1/30/2019 therapy will document any devices changes or modifications on the center communication log.</p> <p>4. Beginning the week of 1/30/2019 an audit of 5 residents fall prevention plans including devices will be completed by the Center Nurse Executive of designee to ensure that fall prevention measures including devices are in place. Audits will be completed weekly for 4 weeks then monthly for 2 months. The results of these audits will be reported to the performance improvement committee for reviews monthly for 3 months or until substantial compliance is achieved.</p> <p>5. The Center Nurse Executive is responsible for monitoring and follow up. Compliance date is 1/30/2019.</p>		

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

PRINTED: 02/06/2019
FORM APPROVED
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER REXBURG CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 660 SOUTH SECOND STREET WEST REXBURG, ID 83440		
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{F 689}	<p>Continued From page 10</p> <ul style="list-style-type: none"> * 1/7/19 at 10:00 PM - "...pain in right hip" * 1/8/19 at 6:00 AM - "Some tenderness to leg noted." * 1/8/19 at 10:00 PM and 1/9/19 at 6:00 AM - "Status of condition: improved." * 1/9/19 at 10:10 AM - "...right hip pain received orders for x-ray..." <p>On 1/8/19 at 4:15 PM, Resident #26 said his pain was adequately managed. His wheelchair was next to his bed and had an anti-roll back bar and anti-tip bars.</p> <p>On 1/9/19 at 11:45 AM, the Occupational Therapist (OT) said he evaluated Resident #26 on 12/20/18, and changed his 20 inch wheelchair to an 18 inch wheelchair to increase his mobility and comfort. The OT said the 20 inch and 18 inch wheelchairs were both equipped with anti-tip bars and neither wheelchair had an anti-roll back bar. The DON was present at the time and said after the fall on 1/6/19, the staff realized Resident #26's wheelchair did not have an anti-roll back bar. The DON said an anti-roll back bar was applied to his wheelchair on 1/7/19, the day after his fall.</p> <p>On 1/9/19 at 12:20 PM, the OT provided a copy of his "side note" to the 12/20/18 evaluation. The side note documented the 18 inch and 20 inch wheelchairs were both equipped with anti-tip bars. The side note did not mention an anti-roll back bar for either wheelchair.</p> <p>On 1/9/19 at 2:30 PM, Resident #26 was observed in his wheelchair next to his bed. He said he fell twice because, "They didn't lock the wheelchair."</p>	{F 689}			

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IDAHO DEPARTMENT OF
HEALTH & WELFARE

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DAVE JEPPESEN – Director

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July 23, 2019

Monte Jones, Administrator
Rexburg Care & Rehabilitation Center
660 South Second Street West,
Rexburg, ID 83440-2300

Provider #: 135105

Dear Mr. Jones:

On **January 9, 2019**, an unannounced on-site complaint survey was conducted at Rexburg Care & Rehabilitation Center. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00008009

ALLEGATION #1:

The facility did not provide tracheostomy care for a resident and she died the next day.

FINDINGS #1:

The complaint was investigated during an unannounced revisit survey conducted at the facility on January 8, 2019 and January 9, 2019.

The clinical records of 11 residents were reviewed. Grievances, Resident Council minutes, Incident and Accident (I&A) reports, and investigations of allegations of abuse/neglect, for 3 months were reviewed. Policies and procedures regarding respiratory care were also reviewed. Multiple staff were observed as they interacted with and responded to residents' needs and requests; and, several nurses and Certified Nursing Assistants (CNAs) were observed as they provided direct care for 7 individual residents. Interviews were conducted with several residents

and nurses, as well as the Director of Nursing Services (DNS).

At the time of the survey, no residents in the facility had a tracheostomy.

One resident's clinical record documented her cognition was intact and she was able to communicate her needs to the staff. It documented she had a tracheostomy and her respiratory care, including oxygen use and tracheostomy care, were provided according to her physician's orders and care plan. The record documented she became anxious sometimes when her tracheostomy needed to be suctioned and the anxiety resolved quickly after her tracheostomy was suctioned. Her respiratory condition was not listed as her cause of death.

The Grievances, Resident Council minutes, I&A reports, and Abuse/Neglect investigations did not document concerns related to inadequate tracheostomy care.

The nurses said the resident was able to let them know when her tracheostomy needed to be suctioned. They said her tracheostomy did not need to be suctioned on some shifts and other times it needed to be suctioned several times a shift, which they did. The nurses stated they observed the resident laughing and visiting with other residents within minutes after her tracheostomy was suctioned. The DNS said she had not received any reports or complaints about inadequate tracheostomy care.

Based on the investigative findings, the allegation was not substantiated due to the lack of evidence of inappropriate or inadequate tracheostomy care.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

Residents' medications were not given on time.

FINDINGS #2:

The clinical records of 11 residents were reviewed. Grievances, Resident Council minutes, Incident and Accident (I&A) reports, Abuse/Neglect allegation investigations, and Medication Error reports for 3 months were reviewed. Policies regarding medication administration were also reviewed. Three nurses were observed as they administered medications to residents and several residents were interviewed regarding the administration of their medications. Several nurses and the Director of Nursing Services (DNS) were also interviewed.

The residents' clinical records documented their medications were administered within the accepted time range (one hour before to one hour after the designated time) in accordance with the standard of practice and the facility's medication administration policy.

The Grievances, Resident Council minutes, I&A reports, Abuse/Neglect investigations, and Medication Error reports did not include concerns about late administration of medications.

The nurses were observed administering scheduled medications and as needed medications to residents' in a timely manner. The nurses said they had an hour before or after the scheduled time to administer most medications; and, some medications, such as thyroid medications, antibiotics, and fast acting insulin, needed to be administered at the scheduled time.

The residents said their medications were usually administered on time. They said their medications were occasionally administered 30 to 45 minutes after the scheduled time when the staff were busy handling an urgent or emergent situation. They said they did not have concerns about medications being administered late.

Based on the investigative findings, the allegation was unsubstantiated due to lack of evidence that medications were not administered on time.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

There are not enough nursing staff.

FINDINGS #3:

Grievances, Resident Council minutes, Incident and Accident (I&A) reports, and investigations of allegations of Abuse/Neglect were reviewed. Staffing records were also reviewed. Multiple staff were observed as they responded to residents' call lights. Interviews were conducted with 22 residents, several nurses and Certified Nursing Assistants (CNA), and the Director of Nursing Services (DNS).

The Grievances, Resident Council minutes, I&A reports, and Abuse/Neglect investigations did not include concerns about inadequate staffing. The staffing records documented the facility exceeded the State minimum requirement for nursing staff and the daily nursing assignments documented consistent staffing on all shifts, including weekends.

During the survey, nurses, CNAs, the Unit Manager, the DNS, and the Activity Director were observed answering call lights. The call lights were answered in 10 minutes or less. The CNAs said the nurses and the Unit Manager helped them answer call lights. The nurses and CNAs said there were enough staff to care for residents on all shifts, including the night shift and on weekends.

The residents said their call lights were usually answered in 5 minutes or less. They said occasionally it could take 10-15 minutes but that was not typical.

Based on the investigative findings, the allegation was not substantiated due to lack of evidence of inadequate staffing.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

The facility did not act when a resident appeared to experience a low blood sugar level.

FINDINGS #4:

The clinical records of 4 residents were reviewed related to diabetes management. Facility policies regarding diabetes management, including hypoglycemia (low blood sugar), were reviewed. Grievances, Incident and Accident (I&A) reports, and medication error reports were also reviewed. Three nurses were observed as they monitored residents' blood glucose levels and administered insulin medications. A lunch and a breakfast meal service was observed in both dining rooms. Interviews were conducted with several residents, 5 nurses, a Unit Manager, and the Director of Nursing Services (DNS).

The residents' clinical records documented their blood glucose levels were monitored per their physicians' orders and hypoglycemic episodes were treated quickly according to their physicians' orders and facility policy.

Grievances, Incident and Accident (I&A) reports, and medication error reports did not contain concerns about hypoglycemia.

During the survey, the nurses followed facility policy when they checked residents' blood glucose levels and they administered insulin medications according to the residents' physicians' orders. The nurses were able to state the signs and symptoms of hypoglycemia and hyperglycemia (high blood sugar) and they followed the facility's protocol unless the physician's orders were different,

Monte Jones, Administrator
July 23, 2019
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then they followed those orders.

One resident was observed dozing and leaning forward while sitting at a table in a dining room during a meal observation. The staff monitored the resident and aroused her several times. They said it had been reported that she did not sleep well the night before. When the resident continued to doze off, a nurse took her to her room and checked her blood glucose level. Her blood glucose level was within normal limits. The staff responded appropriately.

One resident said the staff were attentive and they recognized whenever she felt weak because her blood sugar was low. She said they acted quickly and she had no concerns. The other residents said the facility managed their diabetes appropriately and they did not have concerns.

The DNS said she had not had complaints or concerns about diabetic management.

Based on the investigative findings, the allegation was not substantiated due to lack of evidence of inappropriate diabetes management.

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

LT/slj