IDAHO DEPARTMENT OF
HEALTH & WELFARE

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DAVE JEPPESEN – Director

TAMARA PRISOCK—ADMINISTRATOR
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3232 Elder Street
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February 20, 2020

Randy Chambers, Administrator
Temple View Transitional Care Center
660 South Second Street West
Rexburg, ID 83440-2300

Provider #: 135105

Dear Mr. Chambers:

On **February 7, 2020**, a survey was conducted at Temple View Transitional Care Center by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be an isolated deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

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

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **March 2, 2020**. Failure to submit an acceptable PoC by **March 2, 2020**, may result in the imposition of penalties by **March 24, 2020**.

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 **March 13, 2020 (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 **May 7, 2020**. A change in the seriousness of the deficiencies on **March 23, 2020**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been

achieved by
May 7, 2020 includes the following:

Denial of payment for new admissions effective **May 7, 2020**. [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 **August 7, 2020**, 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 Belinda Day, RN or Laura Thompson, RN, Supervisors Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 2; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **May 7, 2020** 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

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 **March 2, 2020**. If your request for informal dispute resolution is received after **March 2, 2020**, 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 Belinda Day, RN, or Laura Thompson, RN, Supervisors, Long Term Care Program at (208)334-6626, option #2.

Sincerely,

Belinda Day, RN, Supervisor
Long Term Care Program

bd/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
	135105		**02/07/2020**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TEMPLE VIEW TRANSITIONAL CARE CENTER	**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 federal recertification and complaint survey conducted at the facility from February 3, 2020 to February 7, 2020. The surveyors conducting the survey were: Brad Perry, LSW, Team Coordinator Mick Brunson, RN Carmen Blake, RN Survey Abbreviations: CNA = Certified Nursing Assistant DNS = Director of Nursing Services LPN = Licensed Practical Nurse 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, record review, policy review, and resident and staff interview, it was determined the facility failed to ensure residents' call lights were within reach for 1 of 12 (Resident #13) residents reviewed for call lights. This deficient practice had the potential to cause harm if the resident could not request assistance when needed or experienced an adverse medical event	F 558	Resident Identified: On or before March 18th, 2020 resident #13 was assessed for injury with no negative findings by the Director of Nursing or designee. A second call light pad was mounted to resident #13 dresser on 2/28/2020 for ease of accessibility to call light when in his wheelchair.	3/18/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/28/2020

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 requiring prompt staff attention. Findings include: The facility's Call Light policy, dated 5/2007, directed staff to place the call device within the resident's reach before leaving the room. Resident #13 was readmitted to the facility on 3/20/19, with multiple diagnoses including multiple sclerosis (a potentially disabling disease of the brain and spinal cord) and lack of coordination. Resident #13's 11/18/19 quarterly Minimum Data Set assessment documented he required two-person assistance for transfers. Resident #13's care plan, dated 7/25/19, directed staff to keep his call light within reach. On 2/4/20 at 8:49 AM, Resident #13 was in his electric wheelchair in his room with the door open. His pad type call light was on top of a plastic drawer unit to the right of his bed. He said he asked staff to place the call pad on top of his bed when he was in his wheelchair because he had a hard time reaching it where it was. He said staff sometimes forgot to place it on his bed. Resident #13 said he could not use his right hand and when the call pad was placed where it was located at that time, it made it hard for him to reach with his left hand because the back of his wheelchair hit his bed when he tried to move into a position where he could attempt to reach it. On 2/4/20 at 1:11 PM, Resident #13 was in his electric wheelchair in his room. His call pad on top of the plastic drawer unit.	F 558	Other Residents Having the Potential to be effected: Current residents residing in the center had call lights assessed for accessibility by the Director of Nursing or designee on or before March 18th, 2020 Systematic Changes: Nursing staff was educated by the Director of Nursing or designee on call light accessibility on or before March 18th, 2020 Members of the Interdisciplinary Team will review call light devices and accessibility on admission, quarterly and as needed. Monitoring: Beginning the week of March 23rd, 2020 the Director of Nursing or designee will audit call light placement for 5 residents 3 times per week for 4 weeks, then monthly for 2 months to ensure call lights are accessible. Results to be discussed during the Performance Improvement meeting for a minimum of 3 months or until compliance sustained. The Director of Nursing is responsible for monitoring and compliance.	

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F 558	Continued From page 2 On 2/5/20 at 8:51 AM, Resident #13 was in his electric wheelchair in his room. His call pad was hanging above the plastic drawer unit. On 2/5/20 at 8:54 AM, the DNS went into Resident #13's room to view the call pad placement. Resident #13 told the DNS that staff sometimes forgot to place it on his bed where he preferred it. She unclipped the call pad and placed it on his bed. On 2/5/20 at 8:57 AM, the DNS said the call pad was out of reach of Resident #13. She said she expected staff to place it where he preferred it and within his reach.	F 558		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns.	F 636		3/18/20

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F 636	Continued From page 3 (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced	F 636		

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F 636	Continued From page 4 by: Based on observation, record review, policy review, and resident and staff interview, it was determined the facility failed to ensure residents' were assessed for the safe use of enabling devices. This was true for 1 of 12 residents (Resident #14) whose assessments were reviewed. This deficient practice placed Resident #14 at risk of injury if the transfer pole in his bedroom was assessed and found to be unsafe for his use. Findings include: The facility's Enabling Device Assessment policy, dated 8/2007, documented assessments of enabling devices were to be completed prior to their use. This policy was not followed. Resident #14 was readmitted to the facility on 11/7/17, with multiple diagnoses including unsteadiness on feet and psychomotor deficit (a slowing-down of thought and a reduction of physical movements). Resident #14's care plan, dated 1/2/20, documented he used a transfer pole during transfers. Resident #14's physician's order, dated 1/2/20, documented an order for a transfer pole. Resident #14's record did not include an enabling device assessment for the transfer pole. On 2/3/20 at 4:42 PM, Resident #14 was on his bed in his room and had a transfer pole 18 inches away from his bed. Resident #14 said he was not sure how to use the transfer pole.	F 636	Resident Identified: On or before March 18th, 2020 resident #14 was assessed by the Director of Nursing or designee for the use of the transfer pole. Resident #14 was found to not use or require the transfer pole and the transfer pole was discontinued on February 28th, 2020. Other Residents Having the Potential to be Effected: Current residents residing in the center using enabling devices were assessed by the Director of Nursing or designee to ensure enabling devices have been assessed, orders received by Physician, Consents in place and Care Plan updates complete on or before March 18th, 2020 Systematic Changes: Licensed Nursing were re-educated by the Director of Nursing or designee on or before March 18th, 2020 on assessment of enabling devices. Members of the Interdisciplinary Team will review enabling device assessments to ensure completion with initiation of enabling devices, quarterly and as needed. Monitoring: Beginning the week of March 23rd, 2020 the Director of Nursing or designee will review 3 enabling devices 3 times per week for 4 weeks, then monthly for 2 months to ensure completion of	

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F 636	Continued From page 5 On 2/4/20 at 10:15 AM, CNA #1 and CNA #2 assisted Resident #14 to transfer from his wheelchair to his bed with a gait belt. CNA #1 encouraged him to use his transfer pole, but he did not to use it. On 2/5/20 at 11:31 AM, CNA #3 said Resident #14 sometimes used his transfer pole. On 2/6/19 at 8:47 AM, the DNS said there was not an assessment completed for Resident #14's transfer pole. She said she expected an assessment to be completed to assess the risks and benefits of the device after it was placed in Resident #14's room.	F 636	assessment. Results to be discussed during the Performance Improvement meeting for a minimum of 3 months or until compliance sustained. The Director of Nursing is responsible for monitoring and compliance.	
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift.	F 732		3/18/20

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F 732	Continued From page 6 (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review, and staff interview, it was determined the facility failed to ensure nurse staffing information was posted daily, at the beginning of each shift, and was complete. This failed practice had the potential to affect the 36 residents residing in the facility and their representatives, visitors, and others who wanted to review the facility's staffing levels. Findings include: The facility's Nurse Staff Posting policy, dated 5/2007, documented the facility posted the number of staff and hours worked by licensed and unlicensed nursing staff directly responsible for residents' care. This policy was not followed. On 2/3/20 at 3:23 PM, the daily nurse staffing information was observed in the hallway near the nurses' station. The posted information was for the day, evening and night shift, and documented	F 732	Residents Identified: On or before March 18th, 2020 staffing hours were posted by the Director of Nursing or designee. Other Residents Having the Potential to be effected: Posting of staffing hours was reviewed in resident council by the Director of Nursing or Designee on or before March 18th, 2020. Systematic Changes: Licensed Nursing were re-educated by the Director of Nursing or designee on or before March 18th, 2020 regarding posting of actual hours worked and to post the staffing hours at the beginning of each shift.	

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F 732	Continued From page 7 the following: * Day Shift: CNAs - 5, LPNs - 1, and RNs - 1 * Evening Shift: CNAs - 5, LPNs - 1, and RNs - 1 * Night Shift: CNAs - 2 and LPNs - 1 * The facility's census was 36 On 2/4/20 at 8:46 AM, the daily nurse staffing information was observed in the hallway near the nurses' station. The posted information was for the day, evening and night shift, and documented the following: * Day Shift: CNAs - 5 and RNs - 2 * Evening Shift: CNAs - 5, LPNs - 1, and RNs - 1 * Night Shift: CNAs - 2 and LPNs - 1 * The facility's census was 36 On 2/5/20 at 8:49 AM, the daily nurse staffing information was observed in the hallway near the nurses' station. The posted information was for the day, evening and night shift, and documented the following: * Day Shift: CNAs - 5, and RNs - 2 * Evening Shift: CNAs - 5 and RNs - 2 * Night Shift: CNAs - 2 and RNs - 1 * The facility's census was 36 The Nurse Staffing postings did not identify the actual hours worked and the information was not posted at the beginning of each shift. On 2/5/20 at 10:35 AM, the Administrator said the nurse staff information was posted for the whole day and not at the beginning of each shift. He said nursing hours were not documented on the form.	F 732	Posted daily nurse staffing data form was changed to reflect the actual hours worked and to be posted at the beginning of each shift. Monitoring: Beginning the week of March 23rd, 2020 the Director of Nursing or designee will review posted staffing hours 3 times per week for 4 weeks, then monthly for 2 months to ensure actual hours worked completed and the form posted at the beginning of the shift. Results to be discussed during the Performance Improvement meeting for a minimum of 3 months or until compliance sustained. The Director of Nursing is responsible for monitoring and compliance.	

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F 732	Continued From page 8 The Nurse Staffing postings from 1/1/20 to 2/2/20 were reviewed. There were no postings for 1/12/20, 1/18/20, 1/19/20, 1/25/20, 1/26/20, 2/1/20, and 2/2/20. On 2/5/20 at 11:00 AM, the Administrator said the postings were not always posted on the weekends. He said he expected the staff postings to be correct and posted daily.	F 732		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;	F 758		3/18/20

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TEMPLE VIEW TRANSITIONAL CARE CENTER	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 758	Continued From page 9 §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and policy review, it was determined the facility failed to ensure physician orders for as needed psychotropic medications were limited to 14 days unless the physician documented rationale for the continued use of the medication and specified a duration for its use. This was true for 1 of 5 residents (Resident #26) who were reviewed for unnecessary medications. This deficient practice created the potential for harm if residents experienced adverse effects from unnecessary psychotropic medications. Findings include: The facility's policy for Psychotropic Drug Use,	F 758	Residents Identified: On or before March 18th, 2020 resident #26 was assessed by the Director of Nursing or designee with no adverse effects noted related to receiving unnecessary medications. Resident #26 had medications discontinued by Physician on February 6th, 2020. Other Residents Having the Potential to be Effected: Residents currently residing in the facility that receive as needed psychotropic medications were reviewed for continued use of the medication by the Director of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135105		02/07/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TEMPLE VIEW TRANSITIONAL CARE CENTER	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 758	Continued From page 10 dated 8/2017, stated as needed orders for psychotropic drugs were limited to 14 days. If the prescribing practitioner believed it was appropriate to extend beyond 14 days, the practitioner was to document the rationale and indicate a duration for the use of the as needed medication in the resident's medical record. This policy was not followed. Resident #26 was admitted on 12/13/19, with diagnoses which included chronic kidney disease and bipolar disorder (mental health disorder causing extreme mood swings). Resident #26 had a physician order for Clonazepam (a psychotropic drug used to treat anxiety), 1 mg tablet as needed daily for anxiety, with a start date of 12/13/19, and an end date documented as "indefinite." The Pharmacist Consultation Summary dated 1/30/20, documented a recommendation to discontinue Resident #26's Clonazepam or to document the indication for its use, intended duration, and rationale for the extended time period. Resident #26's record did not include the physician's rationale for the necessity of the Clonazepam after 14 days. Resident # 26's 2020 MAR (medication administration record), dated 1/1/20 through 1/31/20, documented the as needed Clonazepam was administered on 1/23/20, 1/24/20, 1/25/20, 1/29/20, and 1/31/20.	F 758	Nursing or designee on or before March 18th, 2020 Systematic Changes: Licensed Nursing were re-educated by the Director of Nursing or designee on PRN orders for psychotropic medication use, on or before March 18th, 2020 Members of the nurse management team will review all as needed psychotropic medications with the initiation of medications to ensure medications are limited to 14 days or the attending physician or prescribing practioner indicate the duration for the as needed order. Monitoring: Beginning the week of March 23rd, 2020 the Director of Nursing or designee will review 3 residents receiving as needed psychotropic medications per week for 4 weeks, then monthly for 2 months to ensure psychotropic medication is necessary, or a rational for continuation has been received. Results to be discussed during the Performance Improvement meeting for a minimum of 3 months or until compliance sustained. The Director of Nursing is responsible for monitoring and compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135105		**02/07/2020**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TEMPLE VIEW TRANSITIONAL CARE CENTER	**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 758	Continued From page 11 Resident #26's 2020 MAR, dated 2/1/20 through 2/29/20, documented the as needed Clonazepam was administered on 2/1/20, 2/3/20 (two doses), 2/4/20, and 2/6/20. Resident #26 received a total of 10 doses over a period of 68 days without documentation by the physician to support the use of the as needed Clonazepam beyond 14 days. Additionally, a specified duration for use of the medication was not documented. On 2/6/20 at 3:19 PM, the DNS stated a review of the new orders for Resident #26 did not include a stop date and rationale for continuing the as needed medication beyond 14 days.	F 758		

IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

TAMARA PRISOCK—ADMINISTRATOR
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March 2, 2020

Randy Chambers, Administrator
Temple View Transitional Care Center
660 South Second Street West
Rexburg, ID 83440-2300

Provider #: 135105

Dear Mr. Chambers:

On **February 3, 2020** through **February 7, 2020**, an unannounced on-site complaint survey was conducted at Temple View Transitional Care Center. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00008188

ALLEGATION #1:

Residents were developing pressure ulcers which worsened.

FINDINGS #1:

During the investigation, observations were conducted, resident records were reviewed, and residents and staff wer interviewed.

Three resident records, including a resident admitted May 2013, were reviewed for pressure ulcers. The record of a resident admitted May 2013 did not include documentation the resident had developed or had pressure ulcers. The other two records did not document concerns regarding the care and treatment of their pressure ulcers.

Three residents, including a resident admitted May 2013, were observed for pressure ulcer prevention and no concerns were identified.
Six residents were interviewed and did not express concerns with the development and/or treatment and care of pressure ulcers.
Two nurses were interviewed and said residents received appropriate care to prevent pressure

ulcers. One nurse said, in her experience, the facility provided "excellent pressure ulcer prevention care" for the residents. The Director of Nursing Services (DNS) said residents received appropriate care to prevent pressure ulcers.

Based on the investigative findings, the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

Resident call lights were not responded to in a timely manner.

FINDINGS #2:

During the survey, observations were conducted, Resident Council meeting minutes were reviewed, facility grievances were reviewed, and residents and staff were interviewed.

During observations, no concerns were identified regarding call light wait times.

Resident Council Meeting minutes from June 2019 to January 2020 were reviewed. Resident Council Meeting minutes, dated 11/13/19, documented call light response times were too long at shift change and during meals. Call light audits were completed in November 2019 and the longest documented call light took six minutes to be answered. Resident Council Meeting minutes, dated 12/11/19, documented residents said call light times had improved. The facility grievances from June 2019 to January 2020 were reviewed and no concerns were identified regarding call light wait times.

Six resident interviews were conducted and the residents did not express concerns with call light wait times. Six residents in the group interview said they had no concerns with call light wait times and said their call lights were answered within minutes.

Three nurses and two CNAs said call lights were answered quickly and had no concerns with staff meeting residents' needs. The DNS said call light audits were conducted and the audits documented call lights were answered within minutes. The DNS said there were enough staff to meet residents' needs in a timely manner.

Based on the investigative findings, the allegation could not be substantiated. However, a deficiency was cited at F558 related to the facility's failure to ensure a call light was accessible to a resident.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

Staff were not assisting residents with their meals.

FINDINGS #3:

During the survey, observations were conducted, residents were interviewed, and staff were interviewed.

Resident were observed during three meals. Staff were observed assisting residents who needed assistance and were observed to ask other residents if they needed assistance. A resident who was admitted May 2013, was observed with a plate guard (helps keep food from sliding off the plate) with specialized handled silverware and was also assisted by staff.

Six residents were interviewed and said they had no concerns with receiving assistance with their meals. Three nurses and two CNAs said residents' needs were met. The DNS said residents received the help they needed during meals. The DNS said there were enough staff to meet residents' needs.

Based on the investigative findings, the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

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

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

IDAHO DEPARTMENT OF
HEALTH & WELFARE

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March 3, 2020

Randy Chambers, Administrator
Temple View Transitional Care Center
660 South Second Street West
Rexburg, ID 83440-2300

Provider #: 135105

Dear Mr. Chambers:

On **February 3, 2020** through **February 7, 2020**, an unannounced on-site complaint survey was conducted at Temple View Transitional Care Center. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00008200

ALLEGATION #1:

Call lights were not answered in a timely manner.

FINDINGS #1:

During the survey, observations were conducted, Resident Council meeting minutes were reviewed, facility grievances were reviewed, call light audits were reviewed, and residents and staff were interviewed.

Resident Council Meeting minutes from June 2019 to January 2020 were reviewed. Resident Council Meeting minutes, dated 11/13/19, documented call light response times were too long at shift change and during meals. Call light audits were completed in November 2019 and the longest documented call light took six minutes to be answered. Resident Council Meeting minutes, dated 12/11/19, documented residents said call light times had improved.

The facility grievances from June 2019 to January 2020 were reviewed and no concerns were identified regarding call light wait times.
Six resident interviews were conducted and the residents did not express concerns with call light

wait times. Six residents in the group interview said they had no concerns with call light wait times and said their call lights were answered within minutes.

Three nurses and two CNAs said call lights were answered quickly and had no concerns with staff meeting residents' needs.

The Administrator, stated on 2/6/20 at 4:16 PM, all staff are responsible to answer call lights. Staff are to communicate with each other if a resident has a need that the responding staff member is unable to address. The Administrator stated random call light response time was audited periodically and no concerns were found.

Based on the investigative findings, the allegation could not be substantiated. However, a deficiency was cited at F558 related to the facility's failure to ensure a call light was accessible to a resident.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

Residents are left wet for extended periods and are developing skin wounds because of this.

FINDINGS #2:

During the survey, observations were conducted, resident records were reviewed, residents were interviewed, and staff were interviewed.

Four interviews were conducted with alert and oriented residents and they did not express concerns with receiving care for incontinence. Six additional residents were interviewed during the Resident Group meeting and no concerns were identified related to being left wet for extended periods.

Three residents who were unable to make their needs known, including incontinent care, were observed for care by staff. The facility staff anticipated the resident's needs and provided the needed care. There was no observations of residents being left wet. Residents were also observed to be clean and odor free.

Twelve resident records were reviewed and one resident's record included an admission assessment which documented the resident required extensive assistance of one to two staff for toileting and was frequently incontinent. The resident's record included documentation the staff checked the resident and performed incontinence care every two hours. The resident's record did not include documentation of moisture related skin concerns or wounds on skin checks conducted with each bath/shower and with personal care.

The records of the three residents who were dependent on facility staff for incontinence care

confirmed care was provided as needed and the residents did not develop skin concerns.

The Director of Nursing Services, stated on 2/6/20 at 8:04 AM, staff were to check each resident who was dependent for incontinence care at least every two hours and as needed.

Based on investigative findings, the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

Residents' medical symptoms were not monitored adequately by staff.

FINDINGS #3:

During the survey, twelve resident records were reviewed.

The records of three residents who had a diuretic medication ordered were reviewed and there were no concerns regarding failing to notify the physician with changes. Three residents who had physician orders for supplemental oxygen were reviewed. There were no concerns identified for oxygen administration.

One resident's record included diagnoses of congestive heart failure, severe lymphedema (a long-term condition where excess fluid collects in tissues causing swelling), anemia, left below the knee amputation, and diabetes. The physician's history and physical at admission described the lymphedema as "severe" in her lower extremities. The resident was ordered compression stockings or compression dressings, which the resident refused to use.

The same resident's admission orders included a diuretic. The Lasix dose was adjusted 3 times from 20 milligrams upon admission to 40 mg on 5/7/19 and 80 mg, also on 5/7/19.

On admission, the resident weighed 173 pounds in a wheelchair. Almost 5 months later the resident's weight was 251.8 pounds with a wheelchair. The resident's weight changes were reported to the physician and new orders were received. The physician was notified, and the Lasix order was increased to 80 mg orally.

The Director of Nursing Services, stated on 2/6/20 at 8:04 AM, the physician provided education to the resident regarding her oral intake and the effect the items the resident made choices to eat. The resident had a history of ordering foods and snacks from the internet herself and having them delivered to the facility. The resident made her own decisions and chose not to follow the education provided by staff and the physician.

The resident's record also included a physician order for supplemental oxygen at 2 liters/minute.

The flow rate of the supplemental oxygen was increased to 2.5 liters/minute on 4/5/19. The resident's physician ordered an inhaler treatment to be administered when the resident experienced shortness of breath. The breathing treatments were administered when the resident complained of shortness of breath, which was less than daily.

The resident's physician examined the resident at least monthly and counselled the resident at each examination regarding her dietary intake. Review of the meal intakes for the resident's stay revealed she would eat between 50-100% of the meals served daily.

Based on the investigative findings, the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

Residents' diabetes was not managed properly and they were sent to the hospital for abnormal blood sugar levels.

FINDINGS #4:

During the survey, 12 resident records were reviewed and staff were interviewed.

The records of three diabetic residents documented the facility followed the physician's orders for the monitoring and treatment of the residents' blood sugars.

One resident's record included documentation the facility reported blood sugar readings to the physician weekly and as needed. When a reading was outside of the physician ordered parameters, the facility staff responded with the treatment as ordered. There was no documentation of a physician order to send the resident to the hospital for abnormal blood sugar levels.

The resident's record documented their blood sugar was checked four times a day. The record documented the physician was notified weekly of the resident's lowest blood sugar reading, the average blood sugar reading, and the highest blood sugar readings for each of the time periods. The communication with the physician also included the current order for diabetic treatment, and any other pertinent information.

The resident's record documented the physician was notified the resident had a blood sugar greater than 250 mg/dL at 7:00 AM, three times at 11:00 AM, three times at 5:00 PM and four times at 9:00 PM notifications on record. The resident's record also documented the physician was notified the resident had a blood sugar less than 70 one time.

The resident's record documented they had a blood sugar of 69 mg/dL, which was low according

to professional standards of practice. The record stated the nurse administered juice as ordered and rechecked the blood sugar 10-15 minutes later, with a reading of 149 mg/dL. There was no evidence in the record of staff failing to respond and notify the physician of blood sugar levels out of acceptable range and as ordered. The provider's notes documented the resident often ate sugary snacks, which would affect blood sugars.

The Director of Nursing Services, stated on 2/6/20 at 8:04 AM, the physician provided education to the resident regarding her oral intake and the items the resident was eating, which would affect blood sugar readings.

Based on the investigative findings, the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

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

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