



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

BRAD LITTLE – Governor  
DAVE JEPPESEN – Director

TAMARA PRISOCK—ADMINISTRATOR  
LICENSING & CERTIFICATION  
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BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, Idaho 83720-0009  
PHONE: (208) 334-6626  
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E-mail: [fsb@dhw.idaho.gov](mailto:fsb@dhw.idaho.gov)

March 15, 2019

Jason Jensen, Administrator  
Bingham Memorial Skilled Nursing & Rehabilitation  
98 Poplar Street  
Blackfoot, ID 83221-1758

Provider #: 135007

Dear Mr. Jensen:

On **March 1, 2019**, a survey was conducted at Bingham Memorial Skilled Nursing & Rehabilitation by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be one that comprises a pattern that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

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

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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 **March 25, 2019**. Failure to submit an acceptable PoC by **March 25, 2019**, may result in the imposition of penalties by **April 17, 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; 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 **April 5, 2019 (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 30, 2019**. A change in the seriousness of the deficiencies on **April 15, 2019**, may result in a change

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in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **May 30, 2019** includes the following:

Denial of payment for new admissions effective **June 1, 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 **September 1, 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 **May 30, 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:

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<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:

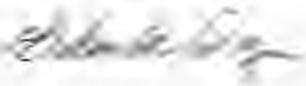
- BFS Letters (06/30/11)

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

This request must be received by **March 25, 2019**. If your request for informal dispute resolution is received after **March 25, 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 Debby Ransom, RN, RHIT, Bureau Chief at (208) 334-6626, option 5.

Sincerely,



Belinda Day, RN, Co-Supervisor  
LTC, Bureau of Facility Standards

bd/dr

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

PRINTED: 03/28/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135007</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/01/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>BINGHAM MEMORIAL SKILLED NURSING &amp; REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>98 POPLAR STREET BLACKFOOT, ID 83221</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 and complaint investigation survey conducted February 25, 2019 through March 1, 2019.  The surveyors conducting the survey were:  Edith Cecil, RN, Team Coordinator Marcia Mital, RN  Abbreviations:  BM - bowel movement CNA - Certified Nursing Assistant cc - cubic centimeter COPD - chronic obstructive pulmonary disease LSW - Licensed Social Worker MAR - medication administration record MD - Medical Doctor mg - milligram MDS - Minimum Data Set PRN - as needed RN - Registered Nurse	F 000			
F 568 SS=E	Accounting and Records of Personal Funds CFR(s): 483.10(f)(10)(iii)  §483.10(f)(10)(iii) Accounting and Records. (A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. (B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. (C)The individual financial record must be	F 568		3/29/19	

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

TITLE

(X6) DATE

Electronically Signed

03/21/2019

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 568	<p>Continued From page 1 available to the resident through quarterly statements and upon request. This REQUIREMENT is not met as evidenced by:</p> <p>Based on facility policy review, staff interview, and record review, it was determined the facility failed to ensure resident personal funds were maintained in separate accounts and quarterly statements were provided for 7 of 8 residents (#3, #4, #5, #10, #18, #20, and #37) whose personal funds were reviewed. The failure created the potential for harm if the residents or their representatives had concerns about their personal fund account, including inaccuracies, that were not addressed. Findings include:</p> <p>The facility's policy for transactions involving resident funds, dated 2/20/19, documented the following:</p> <ul style="list-style-type: none"> <li>* The facility will establish and maintain a system that assures a complete and separate accounting of each resident's personal funds.</li> <li>* Quarterly statements will be provided in writing to the resident, or the resident's representative, within 30 days after the end of the quarter and upon request.</li> <li>* The facility will ensure resident funds are not comingled with facility funds or funds of someone other than a resident.</li> </ul> <p>On 2/28/19 at 9:40 AM, the facility's Patient Financial Counselor, stated she did not manage residents' personal fund accounts. She stated CNA #1 provided resident transportation and managed the personal funds accounts for the</p>	F 568	<p><b>*CORRECTIVE ACTIONS FOR RESIDENT SPECIFIC:</b> -Residents #3, #4, #5, #10, #18, #20, and #37 were provided quarterly statements by March 29, 2019</p> <p><b>*CORRECTIVE ACTION FOR POTENTIAL RESIDENTS THAT MAY BE AFFECTED BY THIS DEFICIENT PRACTICE :</b> -All residents using the resident trust have the potential to be affected by this deficient practice. All residents using the resident trust will receive their most recent quarterly stamen within 30 days from the end of March. - Root cause analysis revealed lack of education to those staff members handling resident trust funds and providing quarterly statements to residents or families.</p> <p><b>*MEASURES(FACILITY SYSTEMS) THAT WILL BE PUT IN PLACE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR:</b> - We believe education is the best prevention. Staff handling resident trust were educated on March 28th on policy involving resident funds and providing quarterly statements to residents or families within 30 days of the end of the quarter and upon request. - We will maintain this by a. education to</p>		

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F 568	Continued From page 2 residents.  On 3/1/19 at 11:03 AM, during an interview with CNA #1, the Administrator, and the Patient Financial Counselor, CNA #1 reviewed current personal funds accounts. CNA #1 stated all the resident funds were in a single account with a local bank. CNA #1 provided a printout of a Trust Account Balance Sheet as of 3/1/19. The ledger identified current balances for Residents #3, #4, #5, #10, #18, #20, and #37. The Administrator stated the residents' money was in one interest bearing account. He said the interest generated from the account went into a Bingham Memorial Hospital account. The Administrator said the interest was then paid out to the individual residents. CNA #1 stated she had not sent out monthly or quarterly statements to residents or families, but she was only in the position a few months. The Administrator stated he did not know the last time statements were sent out. The Patient Financial Counselor stated three residents received statements in September 2018. Prior to that, she was unsure. The Patient Financial Counselor attempted to find previous statements provided for the other residents. She said, "I think it might have been back in March of 2018."	F 568	any staff handling resident trust funds b. continued monitoring of process through random auditing that statements were provided to residents or families each quarter of the year that have funds in the resident trust, after initial 2 quarters of audits.  *MONITORING A.WHO: - Administrator /Designee B.FREQUENCY: - Quarterly audit of 5 residents for 2 quarters of the year. Areas of concern will be immediately addressed. The QA committee will review any issues uncovered by the weekly audits monthly and PRN. C.START DATE: -March 29, 2019  *DATES WHEN CORRECTIVE ACTION IS COMPLETED: - March 29, 2019		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8)  §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The	F 623		3/29/19	

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F 623	<p>Continued From page 3</p> <p>facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.</p> <p>(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and</p> <p>(iii) Include in the notice the items described in paragraph (c)(5) of this section.</p> <p>§483.15(c)(4) Timing of the notice.</p> <p>(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.</p> <p>(ii) Notice must be made as soon as practicable before transfer or discharge when-</p> <p>(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;</p> <p>(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;</p> <p>(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;</p> <p>(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or</p> <p>(E) A resident has not resided in the facility for 30 days.</p> <p>§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:</p> <p>(i) The reason for transfer or discharge;</p> <p>(ii) The effective date of transfer or discharge;</p>	F 623			

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F 623	<p>Continued From page 4</p> <p>(iii) The location to which the resident is transferred or discharged;</p> <p>(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;</p> <p>(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;</p> <p>(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and</p> <p>(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.</p> <p>§483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.</p> <p>§483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who</p>	F 623			

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F 623	<p>Continued From page 5</p> <p>is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff and family interview, facility policy review, and record review, it was determined the facility failed to ensure transfer notices were provided in writing to residents upon transfer. This was true for 2 of 2 residents (#12 and #25) reviewed for transfers. This deficient practice had the potential for harm if residents were not made aware of or able to exercise their rights related to transfers. Findings include:</p> <p>The facility's policy and procedure for Transfer and Discharge, dated 10/2018, directed staff to notify the resident/resident representative for facility initiated emergency transfers and/or discharges for medical reasons.</p> <p>1. Resident #25 was admitted to the facility on 1/28/19 with multiple diagnoses which included coronary artery disease and COPD.</p> <p>A nurse's note, dated 2/11/19, documented Resident #25 was transferred to the emergency room for evaluation and treatment. The note documented Resident #25's wife was called and notified of the transfer. Resident #25's record did not include documentation he or his representative received a written notification of the reason for transfer to the hospital.</p>	F 623	<p>*CORRECTIVE ACTIONS FOR RESIDENT SPECIFIC: -Residents #12 and #25 were already residing back in the facility by March 29, 2019</p> <p>*CORRECTIVE ACTION FOR POTENTIAL RESIDENTS THAT MAY BE AFFECTED BY THIS DEFICIENT PRACTICE : -All residents have the potential to be affected by this deficient practice. Residents will be notified as required for facility initiated transfers or discharges - Root cause analysis revealed lack of education to nurses and social services (who may be involved in transfers and discharges) on the process of notifying the resident or family and/or applicable agencies required through regulations, for the move and in the required timeframes required through regulations.</p> <p>*MEASURES(FACILITY SYSTEMS) THAT WILL BE PUT IN PLACE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR: -We believe education is the best</p>		

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F 623	<p>Continued From page 6</p> <p>On 2/27/19 at 1:23 PM, Resident #25's wife stated the facility did not provide written notification of her husband's transfer to the hospital. She stated the facility did not contact her. She stated she found out Resident #25 was transferred to the hospital when she came to see him.</p> <p>On 2/27/19 at 2:35 PM, RN #3 stated the family is called when a resident is transferred to the hospital but was not familiar with any transfer/discharge papers from the facility.</p> <p>On 2/27/19 at 2:50 PM, the LSW stated Social Services did not provide written notice of transfer and discharge to residents.</p> <p>On 2/27/19 at 3:15 PM, the Patient Financial Counselor stated she did not provide residents with written notice of transfer or discharge.</p> <p>2. Resident #12 was admitted to the facility on 9/12/17 with multiple diagnoses which included depression and bipolar disorder.</p> <p>a. A nurse's note, dated 1/7/19, documented Resident #12 was observed to be anxious at the nurses' station. He was hitting his head with both fists. Resident #12 stated he was going to try and kill himself. Resident #12 agreed to physician notification and inpatient psychiatric observation if needed.</p> <p>A physician's order, dated 1/7/19, directed staff to admit Resident #12 to an inpatient hospital psychiatric unit for suicidal ideations.</p>	F 623	<p>prevention. Nursing staff and social services were educated on March 28th on the policy for Notice before Discharge including notification before, timing, contents of the notice, changes to the notice, and notice in advance of facility closure.</p> <p>- We will maintain this by a. nursing and social services education b. auditing transfers or discharges to make sure notices were provided as per regulations and policy c. continued monitoring of process through random audits after initial audits are satisfactory</p> <p><b>*MONITORING</b> A.WHO: - Social Services /Designee B.FREQUENCY: - Weekly audits of 2 Residents (if any facility initiated transfers or discharges were done in that week) for 6 weeks. Areas of concern will be immediately addressed. The QA committee will review any issues uncovered by the weekly audits monthly and PRN. C.START DATE: -March 29, 2019</p> <p><b>*DATES WHEN CORRECTIVE ACTION IS COMPLETED:</b> - March 29, 2019</p>		

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F 623	Continued From page 7 On 1/7/19, Resident #12 was transferred to a hospital psychiatric unit for treatment.  b. A nurse's note, dated 2/3/19, documented Resident #12 verbalized suicidal intent to staff.  A physician's order, dated 2/3/19, directed staff to transfer Resident #12 to a hospital psychiatric unit for suicidal ideation.  On 2/3/19, Resident #12 was transferred to a hospital psychiatric unit for treatment.  Resident #12's record did not document Resident #12 or his representative were provided written notice of transfer for either transfer.  On 2/27/19 at 2:35 PM, RN #3 stated when a resident was transferred, she called the family and sent the chart and a copy of the MAR with the report to the hospital with the resident. She stated she did not know about providing written transfer/discharge information.  On 2/27/19 3:15 PM, the Patient Financial Counselor confirmed the facility did not give residents a written notice of transfer or discharge.	F 623			
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2)  §483.15(d) Notice of bed-hold policy and return-  §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies-	F 625		3/29/19	

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F 625	<p>Continued From page 8</p> <p>(i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;</p> <p>(ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;</p> <p>(iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and</p> <p>(iv) The information specified in paragraph (e)(1) of this section.</p> <p>§483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by:</p> <p>Based on family and staff interview, policy review, and record review, it was determined the facility failed to ensure a bed-hold notice was provided to a resident and/or their representative upon transfer to the hospital. This was true for 2 of 2 residents (Resident #12 and #25) who were reviewed for transfers. This deficient practice created the potential for harm if residents were not informed of their right to return to their former bed/room at the facility within a specified time and may cause psychosocial distress if not informed they may be charged to reserve their bed/room. Findings include:</p> <p>The facility's Bed-Hold Notice Upon Transfer policy, dated 8/2018, documented the following:</p>	F 625	<p>*CORRECTIVE ACTIONS FOR RESIDENT SPECIFIC: -Residents #12 and #25 were already residing back in the facility by March 29.</p> <p>*CORRECTIVE ACTION FOR POTENTIAL RESIDENTS THAT MAY BE AFFECTED BY THIS DEFICIENT PRACTICE : -All residents that are transferred to the hospital have the potential to be affected by this deficient practice. Any residents transferred to hospital will be notified of bed hold policy. - Root cause analysis revealed lack of education to nurses and patient financial</p>		

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F 625	<p>Continued From page 9</p> <p>* In the event of an emergency transfer of a resident, the facility will provide within 24 hours, written notice of the facility's bed-hold policies.</p> <p>* The facility will keep a signed and dated copy of the bed-hold notice information given to the resident and/or resident representative in the resident's file.</p> <p>1. Resident #25 was admitted to the facility on 1/28/19 with multiple diagnoses which included coronary artery disease and COPD.</p> <p>A progress note, dated 2/11/19, documented Resident #25 was transferred to the emergency room for evaluation and treatment. The note documented Resident #25's wife was called and notified of the transfer. Resident #25's record did not include documentation he or his representative received a bed-hold notification when he was transferred to the hospital.</p> <p>On 2/27/19 at 1:23 PM, Resident #25's wife stated the facility did not talk with her about holding her husband's bed for his return. She stated she did not remember having signed a bed-hold notice. A bed-hold notice was not found in Resident #25's record.</p> <p>On 2/27/19 at 3:15 PM, the Patient Financial Counselor stated, "We tell the resident verbally that we will do a bed hold. We don't have anything in writing."</p> <p>2. Resident #12 was admitted to the facility on 9/12/17 with multiple diagnoses which included depression and bipolar disorder.</p>	F 625	<p>counselor (staff who may be involved in transfers to the hospital) on the process of notifying the resident or family the bed hold policy, obtaining a signed copy to keep in the resident chart, and applicable timeframes per policy and regulation.</p> <p><b>*MEASURES(FACILITY SYSTEMS) THAT WILL BE PUT IN PLACE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR:</b></p> <p>- We believe education is the best prevention. Nursing staff and patient financial counselor were educated on March 28th on the policy for Bed Hold Notice Upon Transfer including notification, timing, and maintaining a copy in the residents chart.</p> <p>- We will maintain this by a. nursing education b. auditing transfers to the hospital that residents were provided the bed hold notice as per regulations and policy c. continued monitoring of process through random audits after initial audits are satisfactory</p> <p><b>*MONITORING</b> A.WHO: - Patient financial counselor /Designee B.FREQUENCY: - Weekly audits of 2 Residents (if any facility initiated transfers or discharges were done in that week) for 6 weeks. Areas of concern will be immediately addressed. The QA committee will review any issues uncovered by the weekly audits monthly and PRN.</p>		

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F 625	Continued From page 10  a. A progress note, dated 1/7/19, documented Resident #12 was observed to be anxious at the nurses' station. He was hitting his head with both fists. Resident #12 stated he was going to try and kill himself. Resident #12 agreed to physician notification and inpatient psychiatric observation, if needed.  A physician's order, dated 1/7/19, directed staff to admit Resident #12 to an inpatient hospital psychiatric unit for suicidal ideations.  On 1/7/19, Resident #12 was transferred to an inpatient hospital psychiatric unit for treatment.  b. A progress note, dated 2/3/19, documented Resident #12 verbalized suicidal intent to staff.  A physician's order, dated 2/3/19, directed staff to transfer him to an inpatient hospital psychiatric unit for suicidal ideation.  On 2/3/19, Resident #12 was transferred to an inpatient hospital psychiatric unit for treatment.  Resident #12's record did not document Resident #12, or his representative was provided with the facility's bed-hold policy information for either transfer.  On 2/27/19 at 2:35 PM, RN #3 stated when a resident was transferred, she called the family and sent the chart and a copy of the MAR with the report to the hospital with the resident. She stated she did not know about providing written bed-hold information.	F 625	C.START DATE: -March 29, 2019  *DATES WHEN CORRECTIVE ACTION IS COMPLETED: -March 29, 2019		



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F 684	<p>Continued From page 12</p> <p>The 5 day MDS assessment, dated 2/21/19, documented Resident #25 had impaired cognition.</p> <p>Resident #25's admission physician's order, dated 1/28/19, included the following:</p> <ul style="list-style-type: none"> <li>* If no BM day 2: Milk of Magnesia 30 cc by mouth 1 dose if not contraindicated, as needed.</li> <li>* If no BM day 2: Dulcolax 10 mg by mouth 1 dose if no results from Milk of Magnesia, if not contraindicated, as needed.</li> <li>* If no BM day 3: Dulcolax 10 mg rectal suppository 1 dose if not contraindicated, as needed.</li> <li>* If no BM day 3: Fleets enema per rectum 1 dose if not contraindicated, as needed.</li> <li>* If no BM day 3: If no results from enema, notify MD, as needed.</li> </ul> <p>The facility's policy and procedure for tracking bowel movements, dated 5/15/18, documented the following:</p> <ul style="list-style-type: none"> <li>* Bowel tracking protocol is to establish a system for the facility to track resident bowel movements, detect abnormalities of bowel movements, and implement appropriate interventions to prevent constipation and complications associated with constipation.</li> <li>* Bowel movement activity will be recorded in the vital section of the facility electronic record indicating whether the resident did or did not have a bowel movement on the shift and the size of the bowel movement.</li> </ul>	F 684	<p>the change. A special instruction was written in the MAR to not administer medication within 2 hours of other medications.</p> <p><b>*CORRECTIVE ACTION FOR POTENTIAL RESIDENTS THAT MAY BE AFFECTED BY THIS DEFICIENT PRACTICE :</b></p> <ul style="list-style-type: none"> <li>-All residents have the potential to be affected by this deficient practice. Nurses are documenting appropriately for bowel tracking, pharmacy reviewed physician orders for medications that should be given at separate times according to physician order, needed corrections made.</li> <li>- Root cause analysis revealed that license staff were not following the facility bowel tracking and medication order policy and lack of education to can regarding the importance of documenting resident bowel movement.</li> </ul> <p><b>*MEASURES(FACILITY SYSTEMS) THAT WILL BE PUT IN PLACE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR:</b></p> <ul style="list-style-type: none"> <li>-We believe that education is the best prevention. A License Nurse meeting was held on March 28 to review and educate staff regarding the facility bowel tracking, medication order policy /procedure and the rationale for resident bowel movement documentation.</li> <li>-We will maintain this by a. staff education b. continued monitoring of process through audits of resident bowels tracking report to validate if resident's bowel care are provided in a timely manner and audit</li> </ul>		

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F 684	<p>Continued From page 13</p> <p>Resident #25's medical record documented the following:</p> <ul style="list-style-type: none"> <li>* From 2/1/19 - 2/6/19, for 6 days, there was no documentation of BMs.</li> <li>* From 2/8/19 - 2/11/19, for 4 days, there was no documentation of BMs.</li> <li>* From 2/11/19 - 2/14/19, Resident #25 was out of facility.</li> <li>* From 2/15/19 - 2/20/19, for 6 days, there was no documentation of BMs.</li> <li>* From 2/25/19 - 2/27/19, for 3 days, there was no documentation of BMs.</li> </ul> <p>Resident #25's MARs from 1/28/19 to 2/28/19, did not include documentation bowel care medications were provided as ordered by the MD.</p> <p>2. Resident #189 was admitted to the facility on 2/22/19, following surgical repair of a left hip fracture.</p> <p>Resident #189's admission physician orders, dated 2/23/19, included the following:</p> <ul style="list-style-type: none"> <li>* If no BM day 2: Milk of Magnesia 30 cc by mouth x 1 dose if not contraindicated, as needed.</li> <li>* If no BM day 2: Dulcolax 10 mg by mouth x 1 dose if no results from Milk of Magnesia, if not contraindicated, as needed.</li> <li>* If no BM day 3: Dulcolax 10 mg rectal suppository x 1 dose if not contraindicated, as needed.</li> <li>* If no BM day 3: Fleets enema per rectum x 1 dose if not contraindicated, as needed.</li> <li>* If no BM day 3: If no results from enema, notify MD, as needed.</li> </ul>	F 684	<p>of physician orders and the MAR to evaluate if medication administration time is consistent with physician order c .continued monitoring of process through random audits after initial audits are satisfactory.</p> <p><b>*MONITORING</b> A.WHO: - DNS /Designee B.FREQUENCY: - Weekly audit of 5 residents a week x6 weeks. Areas of concern will be immediately addressed. The QA committee will review any issues uncovered by the weekly audits monthly and PRN. C.START DATE: -March 29, 2019</p> <p><b>*DATES WHEN CORRECTIVE ACTION IS COMPLETED:</b> -March 29, 2019</p>		

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F 684	<p>Continued From page 14</p> <p>Resident #189's medical record documented, he had 2 BMs on 2/23/19.</p> <p>Resident #189's MARs, dated 2/22/19 to 2/28/19, did not include documentation bowel care medications were provided as ordered by the physician.</p> <p>On 2/26/19 at 10:30 AM, Resident #189 stated he needed to find out the last time he had a bowel movement. He said, "I think it has been awhile."</p> <p>On 2/27/19 at 10:51 AM, RN #2 stated the 2 BMs were the only documentation she could find for Resident #189.</p> <p>3. Resident #10 was admitted to the facility on 9/14/18, with multiple diagnoses which included Diabetes Mellitus, hypothyroidism and heart failure.</p> <p>A January 2019 physician order, directed staff to provide Resident #10 with Cholestyramine light powder (a medication used to treat chronic diarrhea) 4 grams by mouth twice a day.</p> <p>On 2/11/19, additional physician direction was provided to staff to ensure the Cholestyramine was not administered within 2 hours of other medications.</p> <p>Resident #10's MAR documented she received levothyroxine (medication for hypothyroidism) at 6:00 AM daily.</p> <p>Resident #10's February 2019 MAR documented</p>	F 684			

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F 684	Continued From page 15 Cholestyramine was administered from 2/1/19 to 2/28/19 at 7:00 AM. The MAR documented Resident #10 also received the following medications at 7 AM daily:  * Lasix for edema (a diuretic) * Neurontin (a medication for neuropathy) * Metformin (a medication for high blood sugars) * Metoprolol Tartrate (a medication for high blood pressure) * Oxybutynin Chloride (a medication for urinary incontinence) * Potassium Chloride (a potassium supplement)  Resident #10's February 2019 MAR documented Cholestyramine was administered from 2/1/19 to 2/27/19 at 8:00 PM. The MAR documented Resident #10 also received the following medications at 8:00 PM:  * Metoprolol Tartrate * Potassium Chloride * Neurontin * Simvastatin (a medication for high blood cholesterol)  On 2/28/19 at 5:11 PM, RN #1 stated the physician's order was not followed. She stated Resident #10 continued to get other medications with the Cholestyramine.	F 684			
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)  § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such	F 695		3/29/19	

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F 695	<p>Continued From page 16</p> <p>care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review, policy review, and staff interview, it was determined the facility failed to ensure staff changed and dated residents' oxygen tubing per physician orders and facility policy. This was true for 3 of 4 residents (#6, #8, and #22) reviewed for oxygen use. This failure created the potential for harm from respiratory infections due to the growth of pathogens (organisms that cause illness) in oxygen humidifiers and cannulas. Findings include:</p> <p>The facility's policy and procedure for oxygen administration, dated 8/2018, directed staff to change oxygen tubing and the mask or cannula weekly and as needed if they became soiled or contaminated. Staff are directed to date and initial all oxygen tubing with the date of change.</p> <p>1. Resident #8 was admitted to the facility on 9/17/18 with multiple diagnoses including COPD with shortness of breath.</p> <p>A physician's order, dated 9/17/18, directed staff to change oxygen tubing every week on Sundays and as needed.</p> <p>On 2/25/19 at 1:00 PM, Resident #8 was observed sitting in his room at bedside with his oxygen on. The oxygen tubing was connected to a prefilled bubble humidifier which was connected to an oxygen system on the wall. The</p>	F 695	<p><b>*CORRECTIVE ACTIONS FOR RESIDENT SPECIFIC:</b></p> <p>-Resident #6, #8 and #22 were affected by this deficient practice.</p> <p>-The oxygen tubing of resident #6 and #8 were evaluated and seen to be recently changed on March 24 with the date and initial of staff who changed it.</p> <p>-Resident #22 had a planned discharge to home on March 5.</p> <p><b>*CORRECTIVE ACTION FOR POTENTIAL RESIDENTS THAT MAY BE AFFECTED BY THIS DEFICIENT PRACTICE :</b></p> <p>-All residents with oxygen has the potential of being affected by this deficient practice. All residents on oxygen therapy had the tubing changed and dated appropriately.</p> <p>-Root cause analysis revealed the lack of staff education regarding the facility oxygen policy caused the deficient practice.</p> <p><b>*MEASURES(FACILITY SYSTEMS) THAT WILL BE PUT IN PLACE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR:</b></p> <p>-We believe that staff education is the best prevention. On March 28 staff were educated regarding the facility oxygen</p>		

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F 695	<p>Continued From page 17</p> <p>bubble humidifier was dated, the oxygen tubing was not.</p> <p>Resident #8's February 2019 Treatment Administration Record (TAR) directed staff to change the oxygen tubing every Sunday on nightshift. The oxygen tubing was changed on 2/3/19, 2/10/19, 2/17/19, and 2/24/19.</p> <p>On 2/26/19 at 4:45 PM, RN #3 stated oxygen tubing should be changed weekly and as needed. She stated the tubing was changed every Sunday. RN #3 said nurses initialed on the TAR but did not date oxygen tubing.</p> <p>On 2/26/19 at 5:06 PM, the DON stated staff changed oxygen tubing every Sunday. The DON stated the staff should put a piece of tape on the tubing with the date changed and their signature to identify the date it was changed. The DON stated Resident #8's oxygen tubing was not dated.</p> <p>On 2/27/19 at 10:32 AM, Resident #8 was sitting in his wheelchair in his room. The oxygen tubing was connected to an oxygen delivery system. The oxygen tubing did not have a date. RN #2 stated she was not able to find a date on Resident #8's oxygen tubing.</p> <p>2. Resident #22 was admitted to the facility on 11/27/18, with multiple diagnoses including COPD.</p> <p>A physician's order, dated 1/10/19, directed staff to change oxygen tubing every week on Sunday and as needed.</p>	F 695	<p>policy with special focus on dating and initialing oxygen tubing during weekly change.</p> <p>-We will maintain this by a. staff education b. auditing of targeted residents to evaluate if staff are following oxygen policy during weekly scheduled oxygen tubing change c. continued monitoring of process through random audits after initial audits are satisfactory.</p> <p>*MONITORING A.WHO: -DNS/ Designee B.FREQUENCY: - Weekly audit of 3 residents a week x6 weeks. Any areas of concern noted will be immediately addressed and discussed at the QA (Quality Assurance) meeting ,monthly and PRN C.START DATE: - March 29,2019</p> <p>* DATES WHEN CORRECTIVE ACTION IS COMPLETED: - March 29, 2019</p>	

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

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F 695	Continued From page 18 Resident #8's February 2019 TAR directed staff to change the oxygen tubing every Sunday on nightshift. The oxygen tubing was changed on 2/3/19, 2/10/19, 2/17/19, and 2/24/19.  On 2/26/19 at 3:50 PM, Resident #22 was sitting in her room with oxygen on. The DON stated she was not able to find a date on the oxygen tubing.  3. Resident #6 was admitted to the facility on 5/31/18, with multiple diagnoses including heart failure and depressive disorder.  A physician's order, dated 9/28/18, directed staff to provide Resident #6 with oxygen at 4 liters a minute and to keep oxygen saturations (oxygen levels in blood) above 90%.  Resident #6's care plan, dated 12/13/18, directed staff to change the oxygen tubing weekly.  On 2/25/19 at 2:12 PM, Resident #6 was observed with oxygen on. The oxygen tubing was not dated.  On 2/26/19 at 7:47 AM and 4:05 PM, Resident #6 was observed with oxygen on. The oxygen tubing was not dated.  On 2/26/19 at 4:46 PM, RN #1 confirmed the oxygen tubing was not dated. She stated the oxygen tubing was usually changed every Sunday and the tubing should be dated at that time.	F 695			
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5)	F 756		3/29/19	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135007</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/01/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>BINGHAM MEMORIAL SKILLED NURSING &amp; REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>98 POPLAR STREET BLACKFOOT, ID 83221</b>		
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F 756	<p>Continued From page 19</p> <p>§483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>§483.45(c)(2) This review must include a review of the resident's medical chart.</p> <p>§483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.</p> <p>§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.</p>	F 756			

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F 756	<p>Continued From page 20</p> <p>This REQUIREMENT is not met as evidenced by: Based on policy review, staff interview, and record review, it was determined the facility failed to ensure the pharmacy recognized and reported medication irregularities. This was true for 3 of 3 residents (#6, #10, and #22) whose monthly pharmacy medication reviews were reviewed. This failure created the potential for harm should residents receive medications that were unnecessary, ineffective, or used for excessive duration, or should residents experience adverse reactions from medications.</p> <p>The facility's policy for use of psychotropic drugs, dated 11/2018, documented the following:</p> <p>* PRN orders for psychotropic drugs shall be used only when the medication is necessary to treat a diagnosed specific condition documented in the record, and for a limited duration (i.e. 14 days.)</p> <p>1. Resident #22 was admitted to the facility on 11/27/18, with multiple diagnoses including depression and anxiety.</p> <p>Resident #22's 90-day MDS assessment, dated 2/25/19, documented she was cognitively intact and received antianxiety medications daily.</p> <p>Resident #22's physician orders, dated 11/27/18, directed staff to provide Clonazepam 0.5 mg 4 times daily as needed for anxiety.</p> <p>The Pharmacist Medication Reviews, completed on 11/30/18, 12/30/18, 1/31/19, and 2/26/19 did not have comments or recommendations made</p>	F 756	<p>*CORRECTIVE ACTIONS FOR RESIDENT SPECIFIC:</p> <p>-Resident #6, #10 and #22 were affected by this deficient practice. -Resident #6 Trazodone medication order was clarified on March 1. Resident #6 is to take Trazodone 50 mg every night. The prn Trazodone 50 mg with the instruction to repeat in an hour has been discontinued. -Resident #10 cholestyramine administration time was changed from 7am and 8pm to 0900 and 2200 on March 1. Resident's MAR was reviewed to verify the change. -Resident #22 clonazepam 0.5 mg prn was scheduled to four times a day on February 28. Resident had a planned discharge to home on March 5.</p> <p>*CORRECTIVE ACTION FOR POTENTIAL RESIDENTS THAT MAY BE AFFECTED BY THIS DEFICIENT PRACTICE :</p> <p>-All residents with prn psychotropic medications and residents with medications with special instructions like the timing of administration have the potential of being affected by this deficient practice. Pharmacy reviewed residents medication orders and any on PRN psychotropic drugs for a limited duration of 14 days and changed as needed to meet regulation. -Root cause analysis revealed the following a. lack of frequency of</p>		

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F 756	<p>Continued From page 21 by the Pharmacist.</p> <p>On 2/28/19 at 3:54 PM, the Pharmacist stated if he did not make recommendations, the Monthly Pharmacist Chart Review form had a zero in the comment section. He stated he put his recommendations in the comment section.</p> <p>On 2/28/19 at 4:13 PM, the Pharmacist stated he was not paying attention to the PRN psychotropic medications when he conducted the resident's monthly medication review. He stated he should have been reviewing them.</p> <p>On 3/1/19 at 11:30 AM, the DON confirmed she had not received any recommendations from the Pharmacist for Resident #22.</p> <p>The Pharmacist review of Resident #22 did not include review of PRN medications and whether the orders were in place for more than 14 days.</p> <p>2. Resident #10 was admitted to the facility on 9/14/18, with multiple diagnoses which included Diabetes Mellitus, hypothyroidism, and heart failure.</p> <p>A physician's order, dated 9/14/18, directed staff to provide Resident #10 with Cholestyramine light powder (a medication used to treat chronic diarrhea) 4 grams by mouth twice a day.</p> <p>On 2/11/19, additional physician direction was provided to staff to ensure the Cholestyramine was not administered within 2 hours of other medications.</p> <p>Resident #10's MAR from September 2018</p>	F 756	<p>Pharmacist review b. lack of attention to the current regulations pertaining to prn use age of psychotropic medications .3.lack of license nurse education when entering medication orders in the MAR caused the deficient practice</p> <p>-The facility administration has decided to replace the outside Pharmacist consultant and have the hospital in house pharmacist who is a board certified geriatric Pharmacist with skilled nursing background take over the consulting Pharmacist duties. This ensures that monthly and daily medication reviews will be performed in a timely manner.</p> <p>- We believe that staff education is the best prevention. License Nurses were educated on 3/28 regarding the facility policy use of Psychotropic drugs with special focus on the use of PRN psychotropic drugs for a limited duration of 14 days. They were also educated on the facility medication order policy.</p> <p><b>*MEASURES(FACILITY SYSTEMS) THAT WILL BE PUT IN PLACE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR:</b></p> <p>- We will maintain this by a. Replacing current Pharmacy consult with in house Pharmacist. b. License Nurse education c. continued monitoring of process through random audits after initial audits are satisfactory.</p> <p><b>*MONITORING</b> A.WHO: -The DNS /Designee</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135007</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/01/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>BINGHAM MEMORIAL SKILLED NURSING &amp; REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>98 POPLAR STREET BLACKFOOT, ID 83221</b>		
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F 756	<p>Continued From page 22 through February 2019, documented Resident #10 received the Cholestyramine medication twice a day at 7 AM and 8 PM with other medications.</p> <p>The Monthly Pharmacist Chart Review documented the Pharmacist reviewed Resident #10's medications on 9/28/18, 10/30/18, 11/30/18, 12/30/18, 1/31/19, and 2/26/19 with no recommendations documented.</p> <p>On 2/28/19 at 6:25 PM, RN #2 stated the Pharmacist should have identified the Cholestyramine was given with other medications with his monthly reviews.</p> <p>The Pharmacist review of Resident #10 did not include review of PRN medications and whether the orders were in place for more than 14 days.</p> <p>On 3/1/19 at 8:40 AM, the Pharmacist stated the administration of Cholestyramine should be separated by a couple of hours from other medications. He stated the medication interacts with Lasix and the Levothyroxine Resident #10 was receiving and should be separated by a couple of hours.</p> <p>On 3/1/19 at 11:27 AM, the DON stated she had not received recommendations from the Pharmacist regarding the administration of Cholestyramine and the administration of Resident #10's other medications.</p> <p>3. Resident #6 was admitted to the facility on 5/31/18 with multiple diagnoses including heart failure and depressive disorder.</p>	F 756	<p>B.FREQUENCY: - Weekly audit of 4 residents a week x6 weeks. Any areas of concern noted will be immediately addressed and discussed at the QA (Quality Assurance )meeting monthly and PRN</p> <p>C.START DATE: - March 29, 2019</p> <p>* DATES WHEN CORRECTIVE ACTION IS COMPLETED: - March 29, 2019</p>		

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

PRINTED: 03/28/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135007</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/01/2019</b>
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F 756	Continued From page 23  A physician's order, dated 7/31/18, directed staff to provide Trazadone (an antidepressant medication used for sleep) 50 mg at bedtime and may provide another dose in one hour if the initial dose was not effective.  On 2/28/19 at 9:47 AM, RN #2 stated the Trazadone was ordered PRN. She stated the order should have only been written for 14 days. She stated she was unable to tell if the Trazadone was repeated in an hour or not because the order was written together on the MAR and the MAR did not have a space for the nurse to document if the Trazadone was repeated in one hour.  The Monthly Pharmacy Chart Review documented Resident # 6's medications were reviewed monthly from 6/30/18 through 2/26/19. Resident #6's Pharmacy Chart Review did not include documentation of recommendations from the Pharmacist.  On 02/28/19 at 3:54 PM, the Pharmacist stated he should have caught the Trazadone may be repeated in an hour as needed.  On 2/28/19 at 4:13 PM, the Pharmacist stated he was not paying attention to the PRN psychotropic medications when he conducted the monthly medication review. He stated he should have been reviewing them.  On 3/1/19 at 11:23 AM, the DON confirmed she had not received recommendations from the Pharmacist for Resident #6.	F 756			
F 812	Food Procurement,Store/Prepare/Serve-Sanitary	F 812		3/29/19	



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F 812	<p>Continued From page 25</p> <p>* Food should be clearly marked to indicate the date or day, by which the food should be consumed or discarded.</p> <p>* The dietary staff are responsible for checking the refrigerator daily for food items that are expiring and discard accordingly.</p> <p>On 2/28/19 from 11:05 AM to 12:05 PM, an inspection of the nursing pantry was conducted with the Nutritional Production Coordinator. A cupboard in the pantry contained a box of 24 four-ounce bottles of Ensure. The expiration date was 7/1/18. There were 4 four-ounce bottles of Ensure in the refrigerator with the expiration date of 7/1/18.</p> <p>The refrigerator in the pantry had a bowl with what appeared to be ham. There was no label or date on the product. There was a bag of what appeared to be turkey. There was no label or date on the product. The Nutritional Production Coordinator stated the items should have been labeled and dated.</p>	F 812	<p>education to dietary and nursing staff on checking for expiration dates and discard dates for other food items brought or stored in the pantry.</p> <p>-We believe education is the best prevention. Dietary and Nursing staff were educated on March 28th on checking items in the pantry for expiration dates or discard dates (for other items stored) and discarding accordingly.</p> <p><b>*MEASURES(FACILITY SYSTEMS) THAT WILL BE PUT IN PLACE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR:</b></p> <p>- We will maintain this by a. dietary and nursing education b. auditing of pantry for expired or discard dates on items stored there c. continued monitoring of process to check for expiration or discard dates and discarding as appropriate.</p> <p><b>*MONITORING</b></p> <p>A.WHO: -The Restorative CNA / Designee</p> <p>B.FREQUENCY: - Weekly audit of pantry 2 times a week for 6 weeks for items beyond expiration or discard date. Any areas of concern noted will be immediately addressed and discussed at the QA (Quality Assurance) meeting ,monthly and PRN</p> <p>C.START DATE: - March 29, 2019</p> <p><b>* DATES WHEN CORRECTIVE ACTION IS COMPLETED:</b> -March 29, 2019</p>		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001040</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/01/2019</b>
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NAME OF PROVIDER OR SUPPLIER  <b>BINGHAM MEMORIAL SKILLED NURSING &amp; REHABILITATION CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>98 POPLAR STREET BLACKFOOT, ID 83221</b>
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C 000	<p><b>INITIAL COMMENTS</b></p> <p>The following deficiencies were cited during the facility's state licensure survey conducted at the facility from February 25, 2019 to March 1, 2019.</p> <p>The team members conducting the survey were:</p> <p>Edith Cecil, RN, Team Coordinator</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 and review of Infection Control Committee (ICC) attendance records, it was determined the facility failed to ensure the Medical Director, Director of Nursing, housekeeping services representative, and maintenance services representative participated in ICC meetings at least quarterly. This failure created the potential for negative outcomes for residents, visitors, and staff in the facility. Findings included:</p> <p>On 3/1/19 at 10:30 AM, the facility's Infection Control Program was reviewed with the Administrator. The Administrator stated the ICC on the hospital side met monthly and the Skilled Nursing facility met weekly.</p> <p>Review of the sign-in sheets from February 2018 to January 2019 provided by the facility covering the last 4 quarters, showed the Medical Director, a housekeeping services representative, and a</p>	C 664	<p>*CORRECTIVE ACTIONS FOR RESIDENT SPECIFIC: N/A</p> <p>*CORRECTIVE ACTION FOR POTENTIAL RESIDENTS THAT MAY BE AFFECTED BY THIS DEFICIENT PRACTICE :</p> <p>-All residents have the potential of being affected by this deficient practice. -Root cause analysis revealed the lack of education regarding the state C664 regarding required members of committee caused the deficient practice. -We believe that staff education is the best prevention. An infection control meeting was held March 28. The Infection control Preventionist and the required members of the Infection Control Committee were educated regarding the C664 IDAPA Rule.</p>	3/29/19

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  Electronically Signed	TITLE	(X6) DATE  03/21/19
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Bureau of Facility Standards

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C 664	<p>Continued From page 1</p> <p>maintenance services representative did not attend the monthly meetings during the first quarter from February 2018 to April 2018.</p> <p>The Medical Director, the Director of Nursing, a housekeeping services representative, and a maintenance services representative did not attend the monthly meetings during the second quarter from May 2018 to July 2018.</p> <p>The Medical Director, a housekeeping services representative, and a maintenance services representative did not attend the monthly meetings during the third quarter from August 2018 to October 2018.</p> <p>The Medical Director, a housekeeping services representative, and a maintenance services representative did not attend the monthly meetings during the fourth quarter from November 2018 to January 2019.</p> <p>The Administrator stated he did not believe the required members were always present.</p>	C 664	<p>*MEASURES(FACILITY SYSTEMS) THAT WILL BE PUT IN PLACE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR: -We will maintain this by a. Infection Control Committee education b. auditing Infection Control meeting sign in sheets</p> <p>*MONITORING A.WHO: -The DNS / Designee B.FREQUENCY: - Initial audit initiated March 28, then quarterly thereafter. Any areas of concern noted will be immediately addressed and discussed at the QA (Quality Assurance )meeting ,monthly and PRN C.START DATE: - March 29, 2019</p> <p>* DATES WHEN CORRECTIVE ACTION IS COMPLETED: - March 29, 2019</p>	



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

BRAD LITTLE – Governor  
DAVE JEPPESEN – Director

TAMARA PRISOCK—ADMINISTRATOR  
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August 21, 2019

Jason Jensen, Administrator  
Bingham Memorial Skilled Nursing & Rehabilitation  
98 Poplar Street  
Blackfoot, ID 83221-1758

Provider #: 135007

Dear Mr. Jensen:

On **February 25, 2019** through **March 1, 2019**, an unannounced on-site complaint survey was conducted at Bingham Memorial Skilled Nursing & Rehabilitation. The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00007983**

**ALLEGATION #1:**

The facility did not ensure residents were provided appropriate seating arrangements and not allowed to sit on the floor.

**FINDINGS #1:**

Observations were conducted throughout the facility in resident rooms and common areas, residents, family members and staff were interviewed and records were reviewed.

There were no observations of residents left to sit on the floor. Eight residents were interviewed during the survey and six residents attended a group meeting and were questioned about leaving residents on the floor. No concerns were identified. Three family members and several staff were interviewed throughout the five-day survey, with no concerns identified related to leaving a resident to sit on the floor.

Jason Jensen, Administrator  
August 21, 2019  
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Review of one resident's care plan documented an intervention to allow the resident to sit on the floor per her preference.

During an interview with the Director of Nursing and the Minimum Data Set Coordinator, they said the resident sat on the floor in the past but not recently. They said the resident was delusional and hallucinated and when staff would try to assist the resident to get up, she became combative and refused to get off the floor.

Review of the resident's record documented the resident was found scooting across the floor on her bottom on 12/23/18 and an Accident/Incident report was completed for a fall. Review of the resident's progress notes dated 10/1/18 through 2/27/19 did not include further documentation of the resident sitting on the floor.

In an interview with the resident, she stated she did not remember sitting on the floor, but also stated if she wanted to sit on the floor she would.

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

#### CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

#### ALLEGATION #2:

Facility failed to ensure residents were kept well groomed and dry.

#### FINDINGS #2:

Observations were conducted throughout the facility, records were reviewed, and residents, family members and staff were interviewed.

There were no odors observed indicating a lack of care. Eight residents were interviewed and six residents attended a group meeting and were questioned about their care and any observations of residents who could not speak for themselves. No concerns were identified. Three family members and several staff were interviewed throughout the five-day survey, and no concerns were identified related to a lack of hygiene or personal care for the residents.

Residents were observed throughout the survey as clean and groomed and were assisted with dressing and/or changing of their clothing if soiled. Fourteen resident records were reviewed, and there were no concerns identified in related to a lack of Activities of Daily Living (ADL) care being provided by the facility staff.

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

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

Facility failed to ensure residents were provided with services necessary to prevent or minimize contractures and for resident ambulation via mobility devices such as wheelchairs.

FINDINGS #3:

Observations were conducted throughout the facility, records were reviewed, and residents, family members and staff were interviewed.

Eight residents were interviewed and six residents attended a group meeting and were questioned about their wheelchairs. No concerns were identified. Three family members and several staff were interviewed throughout the five-day survey, with no concerns identified related to increased contractures and residents having difficulty with their wheelchairs.

One resident's record reviewed documented she received therapy for positioning. The resident's therapist stated in an interview, the facility recommended a wheelchair for the resident and obtained the chair. Review of an invoice documented the wheelchair was ordered on 11/8/18 and received on 11/15/18. Review of the resident's record revealed the resident was on a restorative program for range of motion.

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

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

The facility failed to provide Personal Protective Equipment (PPE) when residents had infections and there was an outbreak of Clostridium difficile (C-diff).

FINDINGS #4:

Observations were conducted throughout the facility, records were reviewed, and residents, family members and staff were interviewed.

Jason Jensen, Administrator  
August 21, 2019  
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There were no Residents in isolation during the survey. Eight residents were interviewed and six residents attended the group meeting and were questioned about their isolation procedures at the facility. No concerns were identified.

Three family members and several staff were interviewed throughout the five-day survey, with no concerns identified related to a lack of PPE available when residents have infections.

Review of one resident's record documented the resident was started on treatment for C diff on 11/1/18. In an interview with the resident's nurse, she stated she received the order for the treatment for the C diff and put the resident in isolation that day.

In an interview with the Infection Preventionist, she stated the facility did have some residents with C-diff last year. She stated there were a lot of residents who came from the hospital who had long term antibiotic use and they developed C-diff as a result. The facility educated housekeeping to use bleach when cleaning rooms of residents with C-diff and not their regular cleaning supplies. The facility did rounds to ensure infection protocols were being followed.

Based on 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,



Belinda Day, RN, Supervisor  
Long Term Care Program