



IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

March 26, 2019

Darin Dransfield, Administrator
Franklin County Transitional Care
44 North 100 East
Preston, ID 83263-1326

Provider #: 135059

Dear Mr. Dransfield:

On **March 15, 2019**, a survey was conducted at Franklin County Transitional Care 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.

Darin Dransfield, Administrator
March 26, 2019
Page 2

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 **April 5, 2019**. Failure to submit an acceptable PoC by **April 5, 2019**, may result in the imposition of penalties by **April 28, 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 19, 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 **June 15, 2019**. A change in the seriousness of the deficiencies on **April 29, 2019**, may result in a change in the remedy.

Darin Dransfield, Administrator
March 26, 2019
Page 3

The remedy, which will be recommended if substantial compliance has not been achieved by **June 15, 2019** includes the following:

Denial of payment for new admissions effective **June 15, 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 15, 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 **June 15, 2019** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

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

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

Darin Dransfield, Administrator
March 26, 2019
Page 4

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 **April 5, 2019**. If your request for informal dispute resolution is received after **April 5, 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 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

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

PRINTED: 04/18/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135059	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/15/2019
NAME OF PROVIDER OR SUPPLIER FRANKLIN COUNTY TRANSITIONAL CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 44 NORTH 100 EAST PRESTON, ID 83263		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS The following deficiencies were cited during the federal recertification survey conducted from March 11, 2019 through March 15, 2019. The surveyors conducting the survey were: Edith Cecil, RN, Team Coordinator Theresa Calvert, RN Abbreviations: ADLs - Activities of Daily Living BM - bowel movement CNA - Certified Nursing Assistant DON - Director of Nursing gm - gram LPN - Licensed Practical Nurse MAR - Medication Administration Record MSW - Medical Social Worker mg - milligram mls - milliliters MDS - Minimum Data Set PRN - as needed RN - Registered Nurse	F 000			
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident.	F 657		4/19/19	

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

TITLE

(X6) DATE

Electronically Signed

04/05/2019

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135059	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/15/2019
NAME OF PROVIDER OR SUPPLIER FRANKLIN COUNTY TRANSITIONAL CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 44 NORTH 100 EAST PRESTON, ID 83263		
(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 657	<p>Continued From page 1</p> <p>(C) A nurse aide with responsibility for the resident.</p> <p>(D) A member of food and nutrition services staff.</p> <p>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.</p> <p>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.</p> <p>(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interview and record review, it was determined the facility failed to ensure residents' care plans were regularly reviewed and revised as warranted. This was true for 1 of 21 residents (Resident #16) reviewed for care plan revisions. This failure created the potential for harm if care was not provided, or decisions were made, based on inaccurate or outdated information. Findings include:</p> <p>Resident #16 was admitted to the facility on 6/4/16, with multiple diagnoses including congestive heart failure (weakness of heart leading to a buildup of fluid in the body) and type 2 diabetes mellitus.</p> <p>The bowel monitoring flowsheet for January 2019, documented Resident #16 did not have a bowel movement from 1/8/19 through 1/12/19 (5</p>	F 657	<p>1) Corrective action immediately was to treat the resident appropriately for her constipation condition and change her care plan to better reflect constipation as an area of focus as well as her preferences for bowel care.</p> <p>2) All residents of the facility have the potential to be affected by this practice.</p> <p>3) A care plan review process will be implemented. MDS coordinator will review last assessment for coding of H0600 about constipation. For any resident who has constipation noted in this section, the MDS coordinator will: review resident's current medications for bowel care, discuss with the resident (or resident</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135059	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/15/2019
NAME OF PROVIDER OR SUPPLIER FRANKLIN COUNTY TRANSITIONAL CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 44 NORTH 100 EAST PRESTON, ID 83263		
(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 657	Continued From page 2 days), 1/14/19 through 1/18/19 (5 days), and 1/28/19 through 1/31/18 (4 days). On 3/14/19 at 11:30 AM, the DON stated she was not sure why the care plan did not address Resident #16's bowel care needs. The DON stated Resident #16 went for a time without eating, and maybe it was her usual pattern.	F 657	representative) the bowel care options, and update the resident's care plan to reflect that resident's preferred bowel care of choice. A standardized process of uniform bowel care has been developed for treatment of constipation which will be incorporated in care plans of all residents. This protocol was presented to licensed staff on 4/4/2019. An item was added to the admit checklist that PRN bowel medications will be added to each resident EMAR on admission. MDS nurse will ask new residents about their bowel patterns and care plan accordingly. Standing orders for PRN bowel care have been written and will be reviewed with all physicians at the next Medical Staff Meeting on 4/15/2019, so that treatment can begin promptly upon recognition of the problem. 4) Compliance will be monitored through our standard bowel monitoring procedure "lax list" by nurses and documentation will be completed in the EMR. Night charge nurse will monitor the previous day's "lax list" and print the Follow up Question Report for size of BM. This will show whether the treatment is effective at producing BM. This nurse will then use the medication record to research whether the bowel care protocol is being followed. This monitoring will occur nightly through the month of April followed by twice weekly monitoring for 8 weeks. This will be documented on the QA worksheet and reviewed quarterly with quality		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135059	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/15/2019
NAME OF PROVIDER OR SUPPLIER FRANKLIN COUNTY TRANSITIONAL CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 44 NORTH 100 EAST PRESTON, ID 83263		
(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 657	Continued From page 3	F 657	assessment committee until substantial compliance is achieved.		
F 684 SS=D	<p>Quality of Care CFR(s): 483.25</p> <p>§ 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, review of standing orders, and staff interview, it was determined the facility failed to ensure professional standards of practice were followed for 1 of residents (#20) reviewed for bladder care. This failed practice placed the residents at risk for pain from bladder spam's and bladder infections. Findings include:</p> <p>1. Resident #20 was admitted to the facility on 11/8/18, with multiple diagnoses including morbid obesity and surgical wounds.</p>	F 684	<p>The MDS nurse will review a random sample of care plans one time per week for one month and every other week for a second month to assure the review and revision of care plans. All residents experiencing a change in status will also have their care plans reviewed. Results will be reviewed quarterly with the quality assurance committee until substantial compliance is achieved.</p> <p>1. One resident was affected by F684. A physicians order for catheter irrigation was obtained for affected resident. 2. Any residents with foley catheters have the potential need for irrigation and may be affected. 3. Action taken was to create a standing order which was added to the 'TCU Standing Order' set that states, "May flush foley catheter with Normal Saline up to twice a day as needed for suspected</p>	4/15/19	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135059	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/15/2019
NAME OF PROVIDER OR SUPPLIER FRANKLIN COUNTY TRANSITIONAL CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 44 NORTH 100 EAST PRESTON, ID 83263		
(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 684	Continued From page 4 A physician's order, dated 12/7/18, directed the use of a Foley catheter. The order included direction to change the Foley catheter every month. Resident #20's care plan documented the use of an indwelling catheter, dated 11/14/18 and revised 2/22/19. Care plan interventions directed staff to provide catheter care twice daily to decrease the risk of infection and monitor, record, and report to the physician signs and symptoms of a urinary tract infection, i.e. cloudiness. A nursing progress note, dated 2/9/19, documented Resident #20 had leaking from her catheter. The nurse documented the catheter tubing had sediment and the nurse was able to flush around the sediment but unable to draw urine from the catheter. The nurse documented Resident #20's catheter was changed and there was immediate drainage of yellow urine. A nursing progress note, dated 2/23/19, documented Resident #20's catheter was flushed with sterile normal saline with return of cloudy urine, and then clear. The nurse documented a new catheter bag system was placed because the original catheter tubing was becoming blocked with sediment. A nursing progress note, dated 2/25/19, documented Resident #20's catheter was leaking and when it was flushed with sterile water it leaked. The nurse documented Resident #20's catheter was changed and functioned appropriately.	F 684	occlusion of catheter." These standing orders may be used as needed for duration of 3 days. If irrigation is required for a longer period of time the nurse must obtain an order from the physician. Standing orders will be reviewed and signed by Medical Staff at meeting on 4/15/19. A Policy was made (scheduled to be reviewed/approved by Medical Staff on 4/15/19) that states the reason for catheter irrigation accompanied by a procedure. Nurses were educated on 4/4/19 regarding the policy/procedure for catheter irrigation and new standing order. 4. To ensure compliance with the new policy, Infection Control (IC) Nurse will monitor residents with foleys weekly for proper use of standing orders or physician orders. If noncompliance is found IC nurse will re-educate nurses involved to the correct process. If non-compliance continues, IC will report to DON for further corrective action. IC nurse will report to QM Committee after 3 months of monitoring.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135059	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/15/2019
NAME OF PROVIDER OR SUPPLIER FRANKLIN COUNTY TRANSITIONAL CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 44 NORTH 100 EAST PRESTON, ID 83263		
(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 684	Continued From page 5 Resident #20's record did not include documentation the physician was notified of the cloudy urine or the catheter irrigation/flushes. On 3/14/19 at 11:20 AM, the DON stated there was not an order for the catheter to be flushed or irrigated on the dates completed. The DON stated she expected the licensed staff to have an order.	F 684			
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and review of product safety information, it was determined the facility failed to ensure harmful chemicals were securely stored and inaccessible to residents. This was true for 1 of 13 residents (Resident #14) and all independently mobile and cognitively impaired residents who may come into contact with the chemicals. Failure to safely secure the chemicals created the potential for residents to experience skin, respiratory tract and gastric irritation. Findings include: Resident #14 was admitted to the facility on 2/3/17, with a diagnosis of non-Alzheimer's	F 689	1) Immediate corrective action was to close and lock all doors with access to hazardous chemicals. 2) Residents that could have been affected include all residents who are independently mobile and able to enter the beauty shop without assistance. 3) New policy has been written regarding chemical storage which includes keeping all rooms and cupboards that contain hazardous chemicals locked when not in use and supervised by an employee. All staff will receive training through the SQSS system regarding this new policy prior to 4/19/19.	4/19/19	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135059	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/15/2019
NAME OF PROVIDER OR SUPPLIER FRANKLIN COUNTY TRANSITIONAL CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 44 NORTH 100 EAST PRESTON, ID 83263		
(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 689	<p>Continued From page 6 dementia.</p> <p>A quarterly MDS assessment, dated 1/23/19, documented he was cognitively impaired.</p> <p>Resident #14's care plan documented he was cognitively impaired and staff were directed to cue, reorient, and supervise him as needed.</p> <p>On 3/13/19 at 3:52 PM, the door to the beauty shop was observed to be fully open. Inside the beauty shop was a container of Barbicide concentrate solution observed on the countertop with combs inside it for disinfection. The container of solution was within reach of all residents who entered the shop. The label on the Barbicide concentrate solution documented it was a disinfectant, fungicide, and virucidal (kills viruses) chemical.</p> <p>On 3/13/19 the following were observed:</p> <p>*At 4:07 PM, a maintenance man and two CNAs walked by the open door to the beauty shop but did not shut and lock the door.</p> <p>*At 4:42 PM, Resident #14 propelled his wheelchair down the hall past the beauty shop and stated to the staff, "I will keep going until I find my room." At 4:49 PM, Resident #14 wheeled himself back down the hall and kept looking into the beauty shop as he passed it.</p> <p>*At 4:52 PM, the housekeeper closed, but did not lock the door to the beauty shop.</p> <p>On 3/13/19 at 4:53 PM, Housekeeper #1 said the door to the beauty shop was usually closed and</p>	F 689	<p>4) Monitoring of compliance will be accomplished via random audit of chemical storage by department managers. TCU and Housekeeping Managers or designee(s) will observe areas where chemicals are stored 3 times weekly at various times for 12 weeks and document compliance with policy on QA worksheet. Audits will be reviewed by quality assurance committee until such time that they determine substantial compliance has been achieved.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135059	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/15/2019
NAME OF PROVIDER OR SUPPLIER FRANKLIN COUNTY TRANSITIONAL CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 44 NORTH 100 EAST PRESTON, ID 83263		
(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 689	Continued From page 7 locked. Housekeeper #1 stated she was not sure why the beauty shop door was to be closed and locked. Housekeeper #1 said she locked the beauty shop door after she checked with staff to be sure they were done. On 3/13/19 at 5:00 PM, the DON said the beauty shop door should be closed when no one was in the shop. The DON stated any kind of chemical that was accessible to a resident was a problem because a resident could get the chemical and swallow it, which could make the resident sick. The Safety Data Sheet for Barbicide concentrate, dated 3/4/16, documented the container should be tightly closed. Potential health effects when exposed to Barbicide were skin irritation, eye irritation, respiratory irritation, headache, nausea, dizziness, and other symptoms of central nervous system depression, and ingestion of the Barbicide concentrate may cause gastrointestinal irritation, vomiting, and diarrhea. On 3/15/19 at 9:20 AM, the DON said the facility did not have a policy for the storage of chemicals. The DON stated the facility followed the Safety Data Sheet guidelines for chemical storage and exposure.	F 689			
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.	F 700		4/15/19	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135059	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/15/2019
NAME OF PROVIDER OR SUPPLIER FRANKLIN COUNTY TRANSITIONAL CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 44 NORTH 100 EAST PRESTON, ID 83263		
(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 700	<p>Continued From page 8</p> <p>§483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation.</p> <p>§483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.</p> <p>§483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.</p> <p>§483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview, and record review, it was determined the facility failed to ensure that prior to the placement of bed rails, alternatives to bed rails were attempted, and individual residents were thoroughly assessed for the risk of entrapment. This was true for 2 of 2 residents (#10 and #20) reviewed for bed rails. This failure created the potential for harm from entrapment or injury related to the use of bed rails. Findings include:</p> <p>1. Resident #20 was admitted to the facility on 11/8/18, with multiple diagnoses including morbid obesity, restless leg syndrome, and surgical wounds.</p> <p>Resident #20's March 2019 physician orders did not include direction for the use of 2 half bed rails.</p> <p>Resident #20's care plan documented a self-care</p>	F 700	<p>1) Bed Rail entrapment assessments started immediately for affected residents. Resident #20 requested to have top bed rails up for mobility and bed control. Informed consent was signed and care plan was updated. Resident #10 assessment completed. Bed cover with wedges ordered and installed on bed of this resident to be used with airbed. This was attempted as a less-restrictive device. Resident very specifically request use of the rails along with the new cover. She was assessed and determined that she is safe to have top and bottom side rails up with the wedge cover, and that the side rails will be considered a restraint. Interdisciplinary team assessed that she needs these for safety and mobility. Resident's guardian signed informed consent and agreed with recommendations. Physician order was</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135059	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/15/2019
NAME OF PROVIDER OR SUPPLIER FRANKLIN COUNTY TRANSITIONAL CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 44 NORTH 100 EAST PRESTON, ID 83263		
(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 700	<p>Continued From page 9</p> <p>performance deficit with ADLs, dated 11/14/18, and revised 11/30/18. Interventions included a 1/2 side rail on each side of the bed up for mobility, reposition every 2 hours and as necessary for maintaining skin integrity.</p> <p>On 3/12/19 at 9:30 AM, Resident #20 was observed in bed with 2 half side rails in the upraised position.</p> <p>On 3/12/19 at 11:40 AM, Resident #20 was observed in bed with 2 half side rails in the upraised position. She stated she held on to the side rails to maintain positioning during cares.</p> <p>On 3/13/19 at 9:30 AM, the DON stated the facility did not have an actual form for side rail assessment. The DON provided a Care Plan Review Record dated 2/13/19. The form documented Resident #20 used side rails. She stated the side rails were assessed on a quarterly basis, but the assessments were not documented other than on this form.</p> <p>The facility did not provide side rail assessments for Resident #20 related to risk of entrapment, risk vs. benefits, or installation according to manufactures recommendations. Resident #20's record did not document whether her diagnoses, medical conditions, cognition, size, weight, and fall risk were considered prior to the application of side rails.</p> <p>2. Resident #10 was admitted to the facility on 4/11/15, with multiple diagnoses including cerebral palsy, quadriplegia, and anoxic (complete lack of oxygen supply) brain damage.</p>	F 700	<p>obtained.</p> <p>2) There is potential for all residents to be affected by resident bed rail assessments. It is the new policy of this facility to avoid routine use of bed rails. Therefore, all current residents will be assessed for need and safety in bed rail use. If resident requests bed rail use, an assessment will be conducted for safety. Less restrictive devices will be recommended. Risks and benefits of using bed rails will be explained and informed consents will be signed where appropriate.</p> <p>3) All new residents will be informed of our bed rail policy. Residents who have been assessed and approved for side rail use will have blue tape attached to the bed rail so all staff will know which rails can be used. Residents' care plans will be updated to include bed rail use where appropriate, and consents will be signed according to policy.</p> <p>4) Compliance will be monitored through random audit of at least 10 beds weekly as performed by MDS coordinators and reported at the end of 3 months to the quality assessment committee.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135059	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/15/2019
NAME OF PROVIDER OR SUPPLIER FRANKLIN COUNTY TRANSITIONAL CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 44 NORTH 100 EAST PRESTON, ID 83263		
(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 700	<p>Continued From page 10</p> <p>A quarterly MDS assessment, dated 1/16/19, documented Resident #10 was cognitively impaired, and required extensive assistance of 2 staff with ADLs.</p> <p>A care plan, dated 1/16/19, documented Resident #10 was at high risk for falls due to her involuntary movements. Interventions included the use of side rails to keep her from sliding out of her bed and the staff were directed to re-evaluate Resident #10's side rails quarterly, and as needed, for appropriateness and to ensure they were the least restrictive device for positioning.</p> <p>A care plan, dated 1/24/19, documented Resident #10 was at high risk for falls and she used side rails as a positioning device. The care plan documented Resident #10 was assessed and it was determined it was safe for her to use the side rails.</p> <p>On 3/13/19 at 3:05 PM, Resident #10 was in her bed with two 1/4 side rails in an upraised position on one side.</p> <p>On 3/14/19 at 9:25 AM, Resident #10 was observed in bed with two 1/4 side rails raised on each side of her bed for a total of four side rails. The two side rails near the foot of the bed were padded.</p> <p>Resident #10's March 2019 MAR included a physician order, dated 3/31/19, for side rails.</p> <p>There was no documentation in Resident #10's record the side rails were assessed for safety.</p>	F 700			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135059	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/15/2019
NAME OF PROVIDER OR SUPPLIER FRANKLIN COUNTY TRANSITIONAL CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 44 NORTH 100 EAST PRESTON, ID 83263		
(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 700	Continued From page 11 On 3/14/19 at 4:08 PM, the MDS Nurse stated Resident #10 had four 1/4 side rails on her bed for her safety because due to involuntary movements and risk for falling. The MDS Nurse stated the facility recognized they had a problem with the documentation of why side rails were being utilized, and they had a new form they were going to use to assess the need for side rails. She stated Resident #10's side rail assessments had slipped through the cracks.	F 700			
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		4/19/19	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135059	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/15/2019
NAME OF PROVIDER OR SUPPLIER FRANKLIN COUNTY TRANSITIONAL CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 44 NORTH 100 EAST PRESTON, ID 83263		
(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 12 §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 record review, observation, and staff interview, it was determined the facility failed to ensure a) residents received a psychoactive medication which had resident-specific target behaviors identified and monitored; and b) physician orders for PRN antianxiety medications were time limited. This was true for 2 of 5 residents (#3 and #22) reviewed for unnecessary medications. This created the potential for harm should residents receive psychoactive medications that were unnecessary or used for an excessive duration. Findings include: 1. Resident #3 was admitted to the facility on 11/30/17, with multiple diagnoses including an	F 758	1. Immediate Action included: The medication regimen for RI# 3 was reviewed by the physician. The psychotropic was determined to be required due to anxiety at about 1500 each day. Lorazepam was scheduled at lower dose at 1500. The medication regimen for RI#22 was reviewed with the physician. This PRN medication was not being used except 1 time in 30 days. This medication was discontinued. 2. The facility has determined that all residents have the potential to be affected. A review of all present residents		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135059	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/15/2019
NAME OF PROVIDER OR SUPPLIER FRANKLIN COUNTY TRANSITIONAL CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 44 NORTH 100 EAST PRESTON, ID 83263		
(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	<p>Continued From page 13 anxiety disorder.</p> <p>An annual MDS assessment, dated 12/5/18, documented Resident #3 had moderately impaired cognition and received antianxiety medication daily.</p> <p>A physician's order, dated 5/15/18, directed staff to provide alprazolam 0.5 mg every 8 hours as needed for anxiety related to bulimia nervosa (an eating disorder). The order did not provide specific direction for determining when Resident #3 was to receive the anti-anxiety medication.</p> <p>The MAR for March 2019, documented Resident #3 received one dose of alprazolam 0.5 mg from 3/1/19 to 3/6/19, two doses on 3/7/19, one on 3/8/19, and one on 3/11/19.</p> <p>a. A care plan, dated 12/13/17, and revised on 3/14/19, documented Resident #3 had an anxiety disorder and received psychotropic medications for management of symptoms. The care plan interventions directed staff to administer the anti-anxiety medications as ordered by the physician and to monitor and document adverse reactions.</p> <p>The care plan did not include resident-specific behaviors the staff were to monitor, or interventions staff were to implement when he exhibited behavioral symptoms.</p> <p>The facility Mood Monitoring Form flowsheet provided CNAs 15 standardized choices of exhibited behaviors for symptoms of anxiety. The flowsheet did not provide resident-specific behavior related to anxiety. The form did not</p>	F 758	<p>with PRN Psychotropic medication orders and indication for use was completed on 3/30/19. Actions are in place to discuss with individual physicians and will be documented in the medical record.</p> <p>3. Licensed Nursing staff were inserviced regarding the facility policy for Use of Psychotropic Drugs on April 4, 2019 (Policy to be approved by Medical Staff 4/15/19). A copy of the regulations regarding unnecessary drugs/unnecessary psychotropic meds and the facility policy regarding use of psychotropic drugs will be provided to the physicians and pharmacist as a resource (4/15/19 after approval). The Social worker along with the Interdisciplinary Team developed a method for nursing to monitor specific behaviors (4/1/2019). A behavior assessment has been developed (4/5/2019) and will be completed for each resident who is taking psychotropic medications to assess for behaviors. The targeted behaviors will be monitored by the nursing staff and recorded in the EMR. The social worker will evaluate behaviors and discuss at the Psychotropic meeting monthly. A policy for Behavior management has been developed and will be approved by the Medical Staff on 4/15/19.</p> <p>4. The Director of Nursing Services (DNS) or designee, will complete random weekly audit for six (6) consecutive weeks of new prn medication orders to ensure that the appropriate indications for use of</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135059	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/15/2019
NAME OF PROVIDER OR SUPPLIER FRANKLIN COUNTY TRANSITIONAL CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 44 NORTH 100 EAST PRESTON, ID 83263		
(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	<p>Continued From page 14</p> <p>provide interventions. The flowsheet provided space for hourly documentation of behaviors.</p> <p>There were no documented episodes of exhibited anxiety symptoms for Resident #3 on the March 2019 Mood Monitoring form.</p> <p>b. A Psychotropic Drug Review form, dated 2/28/19, documented Resident #3 received alprazolam 0.5 mg every 8 hours as needed for anxiety since 1/17/18. The form documented the recommendation to continue the alprazolam 0.5 mg every 8 hours as needed for anxiety as Resident #3 continued to ask for this medication often. The documentation did not address the 14-day limit for use of the PRN psychotropic medication, alprazolam.</p> <p>On 3/14/19 at 10:00 AM, the MSW stated the facility's Mood Monitoring Form flowsheet was completed on every resident in the facility. She stated the CNAs document all behavior and communicated with the nurses. The MSW stated she was not familiar with assessing specific behaviors for residents on psychoactive medications. The MSW stated the pharmacist reviewed the psychoactive medications and participated in the Psychotropic Drug review meetings.</p> <p>2. Resident #22 was admitted to facility on 6/2/17, with multiple diagnoses including dementia and Parkinson's disease (progressive nervous system disorder that affects movement).</p> <p>A quarterly MDS assessment, dated 2/27/19, documented Resident #22 had moderate cognitive impairment, had no delusions or</p>	F 758	<p>any prn psychotropic drugs are clearly documented in the medical record and timely re-evaluation is completed. Audit results will be reviewed by the Quality Assurance Committee until such time consistent substantiation compliance has been achieved as determined by the committee.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135059	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/15/2019
NAME OF PROVIDER OR SUPPLIER FRANKLIN COUNTY TRANSITIONAL CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 44 NORTH 100 EAST PRESTON, ID 83263		
(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	<p>Continued From page 15</p> <p>hallucinations, and received psychotropics medications daily. The MDS assessment also stated a gradual dose reduction of Resident #22's psychotropic medication was not documented by a physician as clinically contraindicated.</p> <p>On 3/12/19 at 9:15 AM, Resident #22 was observed in her room. Resident #22 was alert and interacted with the staff in a calm manner.</p> <p>On 3/12/19 at 9:24 AM, Resident #22 was observed in the Activity room. Resident #22 participated in the activity of catching the ball and she was observed to follow directions and was appropriate with her actions.</p> <p>Resident #22's Physician Order summary report dated 3/1/19 through 3/31/19, included the following orders:</p> <ul style="list-style-type: none"> *citalopram hydrobromide (an antidepressant), 10 mg to be given once a day, *Xanax (an antianxiety medication), 0.25 mg to be given once a day, *Xanax 0.25 mg one tablet every eight hours PRN. <p>Resident #22's 2019 MAR, dated 2/1/19 through 2/28/19, documented the PRN Xanax was administered on 2/4/19, 2/6/19, and 2/16/19.</p> <p>A monthly medication review, dated 2/28/19, documented Resident #22 received PRN Xanax nine times in February 2019 while Resident #22's MAR documented she received the PRN Xanax three times in February 2019. There was no documented recommendation from the</p>	F 758			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135059	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/15/2019
NAME OF PROVIDER OR SUPPLIER FRANKLIN COUNTY TRANSITIONAL CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 44 NORTH 100 EAST PRESTON, ID 83263		
(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 16 pharmacist regarding Resident #22's medications and the monthly medication review form was signed by the physician. On 3/14/19 at 2:42 PM, the Pharmacist stated he no longer attended the Psychotropic Drug review meetings. He stated that when he did, he reviewed the medications and made recommendations. He stated he was not aware of the 14-day limitation for PRN psychotropic medications without a physician assessment of ongoing need.	F 758			
F 909 SS=D	Resident Bed CFR(s): 483.90(d)(3) §483.90(d)(3) Conduct Regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment. When bed rails and mattresses are used and purchased separately from the bed frame, the facility must ensure that the bed rails, mattress, and bed frame are compatible. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident interview, and staff interview, it was determined the facility failed to ensure beds and side rails were inspected and maintained as part of an ongoing program. This was true for 1 of 2 residents (Resident #20) reviewed for side rails and created the potential for harm if residents relied on loose mobility bars to prevent a fall from bed. Findings include: Resident #20 was admitted to the facility on 11/8/18, with multiple diagnoses including morbid obesity and surgical wounds.	F 909	1) Immediate corrective action was to inspect all beds, mattresses, and rails as quickly as possible to identify areas of possible entrapment. 2) There is a possibility that all residents could be affected if the beds, mattresses, and side rails do not fit appropriately and may cause an entrapment hazard. 3) Regular maintenance program will be initiated wherein CNAs who are trained utilizing the "Guidance for Industry and FDA Staff: Hospital Bed System Dimensional and Assessment Guidance	4/19/19	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135059	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/15/2019
NAME OF PROVIDER OR SUPPLIER FRANKLIN COUNTY TRANSITIONAL CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 44 NORTH 100 EAST PRESTON, ID 83263		
(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 909	<p>Continued From page 17</p> <p>On 3/12/19 at 10:30 AM, a bariatric bed with 1/4 side rails attached to each side of the frame near the head of the bed was observed in Resident #20's room. Resident #20 stated she used the side rails when the staff turned her during cares.</p> <p>On 3/14/19 at 4:10 PM, the Assistant Administrator stated the CNAs checked all beds on a quarterly basis. She stated they assess the beds to ensure they were functioning up and down, the side rails were tight, etc. The Assistant Administrator stated the CNAs were not formally trained but did have specific criteria they followed when checking the beds. The bed inspection made sure the mattress fit the bed, the bed controls worked, and the bed frame did not harm the resident.</p> <p>On 3/14/19 at 4:20 PM, the Maintenance Director stated the bariatric bed had side rails that were specific for the bariatric bed per the manufacturer recommendation. The Maintenance Director stated bed checks were completed but not on a schedule. He stated the CNAs reported when something was wrong with the beds and maintenance fixed them.</p>	F 909	<p>to Reduce Entrapment" (2006) will perform monthly checks on all beds to assess proper fit of the mattress on the bed, adequate brake function, proper function of the bed controls, assess distances between parts of the bed that may cause an entrapment hazard, and observe for any loose or broken parts on the bed. If any of these are not working properly, the bed will be immediately referred to maintenance for repair. The maintenance staff will also perform bed checks bi-annually to check motors, cords, plugs, and assess for proper installation of bedrails per manufacturers guidelines. Documentation of bed maintenance tasks will be kept by Maintenance Director for a minimum of 3 years.</p> <p>4) CNAs will produce monthly documentation of completion of bed checks and maintenance will produce bi-annual documentation that mechanical bed checks were completed. Auditing of the bed checks will be performed by assistant administrator prior to 4/19/19 for initial completion, then monthly for 6 months. She will report to the quality assurance committee for 6 months to determine compliance.</p>		