

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135140	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/28/2026
NAME OF PROVIDER OR SUPPLIER Madison Carriage Cove Short Stay Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 410 West 1st North Rexburg, ID 83440	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, record review, and staff interview, it was determined the facility failed to ensure a Pre-admission Screening and Resident Review (PASARR) Level 1, was completed prior to admitting 1 of 3 residents (Resident #32) whose medical records were reviewed for PASARR Level 1 screenings. This failure created the potential for harm if residents required but did not receive specialized services for mental health while residing in the facility. Findings include: The facility's Resident Assessment - Coordination with PASARR Program policy dated 12/24/25, documented:- 1. All applicants to this facility will be screened for serious mental disorders or intellectual disabilities and related conditions in accordance with the State's Medicaid rules for screening. - a. PASARR Level I - initial pre-screening that is completed prior to admission. Resident #32 was admitted to the facility on [DATE], with multiple diagnoses including kidney failure and cancer. On 1/28/26 at 8:47 AM, Resident #32's medical record documented her PASRR I dated 12/16/25 had not been received by the facility until 12/16/25, four days after she was admitted to the facility on [DATE]. On 1/28/26 at 9:21 AM, the ADON stated she had not requested or received the PASRR I prior to Resident #32 being admitted on [DATE] but remembered it was missing on 12/16/25 and asked the hospital for the PASRR I on 12/16/25.</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135140	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/28/2026
NAME OF PROVIDER OR SUPPLIER Madison Carriage Cove Short Stay Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 410 West 1st North Rexburg, ID 83440	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, CPAP manufacturers warning guidelines, record review, and interviews, it was determined the facility failed to provide respiratory services consistent with manufacturers warning guidelines and professional standards of practice. This was true for 1 of 2 residents (Resident #8) whose respiratory equipment was observed. This failure created the potential for residents' respiratory equipment to malfunction and possibly increase the risk of fire. Findings include: [NAME] CPAP contained the following manufacturers warning guidelines:- Oxygen supports combustion. Oxygen should not be used while smoking or in the presence of an open flame.- When using oxygen with this system, turn the device on before turning on the (supplemental) oxygen. Turn the oxygen off before turning the device off. This will prevent oxygen accumulation in the device.- Explanation of the Warning: When the device is not in operation and the oxygen flow is left on, oxygen delivered into the tubing may accumulate within the device's enclosure. Oxygen accumulated in the device enclosure will create a risk of fire.- When using oxygen with this system, a [NAME] Respiroincs Pressure Valve must be placed in-line with the patient circuit between the device and the oxygen source. The pressure valve helps prevent the backflow of oxygen from the patient circuit into the device when the unit is off. Failure to use the pressure valve could result in a fire hazard.Resident #8 was initially admitted to the facility on [DATE], and readmitted to the facility on [DATE], with multiple diagnoses including left femur fracture and chronic respiratory failure with hypoxia (a long-term, potentially fatal condition where damaged lungs cannot properly transfer oxygen to the blood, often causing low oxygen levels).On 1/27/26 at 11:26 AM, observed Resident #8's CPAP was turned off however the oxygen was still turned on at 2 lpm and being bled into the CPAP device. On 1/27/26 at 4:40 PM, observed with the Administrator, Resident #8's supplemental oxygen was being bled into his CPAP which was not turned on. Resident #8's CPAP did not have a [NAME] Respiroincs Pressure Valve (which does not allow oxygen backflow into the CPAP device) installed.On 1/27/26 at 4:45 PM, the Administrator stated the oxygen in Resident #8's room should have been shut off when his CPAP was turned off and was not.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135140	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/28/2026
NAME OF PROVIDER OR SUPPLIER Madison Carriage Cove Short Stay Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 410 West 1st North Rexburg, ID 83440	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0732</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Post nurse staffing information every day.</p> <p>Based on observation and staff interview, it was determined the facility failed to ensure daily nurse staffing sheets were maintained for a minimum of 18 months. This failed practice had the potential to affect all residents residing in the facility and their representatives, visitors, and others who wanted to review the facility's staffing levels. Findings include: On 1/27/26 at 2:00 PM, the DON stated she only had daily staffing sheets from when she started her employment with this facility in August 2025. On 1/27/26 at 2:05 PM, the Administrator stated he was not sure what happened to the daily staffing sheets from January 2025 through July 2025.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135140	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/28/2026
NAME OF PROVIDER OR SUPPLIER Madison Carriage Cove Short Stay Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 410 West 1st North Rexburg, ID 83440	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>Based on record review and staff interview, it was determined the facility failed to ensure controlled medications were tracked and kept secure from potential theft and/or diversion. This was true for 1 of 2 medication carts reviewed. This failure created the potential for undetected misuse and/or diversion of controlled medications and had the potential to affect all residents who received controlled medication in the facility. Findings include: On 1/27/26 at 7:50 AM, during the North Hall medication cart audit, observed the narcotic accountability sheets, dated 1/1/26 to 1/27/26, with 1 licensed nurse signature not documented on 1/21/26. On 1/27/26 at 8:12 AM, LPN #1 stated two nurses should have signed the narcotic accountability sheet when they accepted the medication cart or released the medication cart. On 1/28/26 at 4:38 PM, the DON stated two nurses should have signed the narcotic accountability sheet when they accepted the medication cart or released the medication cart.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135140	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/28/2026
NAME OF PROVIDER OR SUPPLIER Madison Carriage Cove Short Stay Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 410 West 1st North Rexburg, ID 83440	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure residents were free of medication preparation and administration errors for 1 of 1 resident (Resident #2) observed for medication preparation and administration of insulin. This failed practice placed the resident at risk for not receiving their prescribed medication dosage and other adverse outcomes. Findings include: Resident #2 was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE], with multiple diagnoses which included diabetes and anxiety. Resident #2's physician orders documented Basaglar KwikPen Subcutaneous Solution Pen-injection 100 Unit/ML (Insulin Glargine) inject 15 units subcutaneously and Insulin Lispro Injection Solution 100 Unit/ML (Insulin Lispro) as per sliding scale. On 1/27/26 at 8:27 AM, observed LPN #1 remove Glargine insulin pen from the medication cart and dial the insulin pen to 15 Units as ordered. LPN #1 did not prime the insulin pen with 2 Units before dialing the ordered dose. On 1/27/26 at 8:32 AM, LPN #1 administered the Glargine insulin to Resident #2. On 1/27/26 at 8:37 AM, LPN #1 stated she did not prime the insulin pen today and sometimes will prime the pen prior to administering insulin. On 1/28/26 at 4:18 PM, the DON stated insulin pens should be primed with 2 units prior to administering the ordered insulin dosage.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135140	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/28/2026
NAME OF PROVIDER OR SUPPLIER Madison Carriage Cove Short Stay Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 410 West 1st North Rexburg, ID 83440	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>Based on observations, policy review and staff interviews it was determined the facility failed to ensure medications were properly stored, not expired, and disposal of unused medications. This was true for the facility. This failure created the potential for residents to receive expired medications with decreased efficacy or cross contamination from topical products. Findings include: The facility's policy, Destruction of Unused Drugs dated 12/29/25, documented.unused, unwanted and non-returnable medications should be removed from their storage area and secured until destroyed.The following was observed during the medication cart audits. On 1/28/26 at 8:52 AM, the South Hall medication cart was audited with LPN #2 present. Observed the following: - one bottle of Gas Relief with a manufacturer expiration date of 7/25 printed on the bottle On 1/28/26 at 8:53 AM, LPN #2 stated, the bottle of Gas Relief should have been discarded and had not been. On 1/28/26 at 2:01 PM, the North Hall medication storage room was audited with LPN #1 present. Observed the following in the available supplies for resident use: - One tube of barrier cream with a prescription label affixed to the product for resident who had been discharged from the facility on 10/3/25. - One tube of barrier cream with a prescription label affixed to the product for resident who had been discharged from the facility on 11/18/25. On 1/28/26 at 4:38 PM, the DON stated the expired and unused medications should have been removed from the medication cart and storage room and had not been.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135140	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/28/2026
NAME OF PROVIDER OR SUPPLIER Madison Carriage Cove Short Stay Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 410 West 1st North Rexburg, ID 83440	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on the FDA Food Code, policy review, observation, and interview, the facility failed to ensure food was appropriately stored, distributed, and labeled. This deficient practice had the potential to affect all residents who received meals prepared in the facility's kitchen. This placed residents at risk for potential contamination and use of spoiled foods, and adverse health outcomes including food-borne illnesses. Findings include: The FDA Food Code 2022, 3-501.17 documented, Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking . refrigerated, ready-to-eat, time/temperature control for safety food prepared and held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded when held at a temperature of 5 C (41 F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1. The facility's Food Safety Requirements policy dated 12/8/25, documented Facility staff shall inspect all food, food products, and beverages for safe transport and quality upon deliver/receipt and ensure timely and proper storage. iv. Labeling, dating, and monitoring refrigerated food, including, but not limited to leftovers, so it is used by its use by date, or frozen (where applicable)/discarded; v. and Keeping foods covered or in tight containers. On 1/20/26 from 7:45 AM - 8:05 AM, with the FSM present, an initial tour and observation of the kitchen was conducted with the following results: Walk-in freezer:- an open box containing frozen French bread dough, not covered, sealed, or dated.- an open bag containing frozen chicken breast, not sealed, or dated.- a loaf of sliced bread in a bag laying on the floor between the wall and the shelving. The FSM picked up the loaf of bread from the floor and stated it must have fallen off the shelf and the French bread and chicken breast should have been sealed and dated. Walk-in refrigerator:- container of heavy cream with a best by date of 1/18/26. The FSM discarded the heavy cream and stated it was recently ordered and did not notice the best by date of 1/18/26.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135140	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/28/2026
NAME OF PROVIDER OR SUPPLIER Madison Carriage Cove Short Stay Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 410 West 1st North Rexburg, ID 83440	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, observation, and staff interview, it was determined the facility failed to ensure infection control prevention practices were maintained when 1) residents consumed meals prepared in the facility kitchen, and 2) residents received insulin injections to manage their diabetes. These failures put residents at risk for adverse outcomes including potential infections or food-borne illness due to cross contamination. Findings include: The facility's Handwashing Guidelines-Dietary Employees, dated 12/8/25, documented Dietary employees shall clean their hands and exposed portions of their arms immediately before engaging in food preparation including working with exposed food, clean equipment, utensils, and unwrapped single service and single use articles and in the following situations:a. Every time an employee enters the kitchen; at the beginning of the shift; after returning from break; after using the toilet.b. After hands have touched anything unsanitary, i.e., garbage, soiled utensils/equipment, dirty dishes, etc.c. After hands have touched bare human body parts other than clean hands (such as face, nose, hair etc.).d. After coughing, sneezing, or blowing your nose, using tobacco, eating or drinking.e. After handling chemicals and before beginning to work with food.f. While preparing food, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks.g. When switching between working with raw food and working with ready to eat food.h. Before donning gloves for working with food.i. After caring for or handling service animals or aquatic animals.j. After engaging in any activity that may contaminate the hands.The facility's Food Safety Requirements policy, dated 12/8/25, documented Staff shall adhere to safe hygienic practices to prevent contamination of foods from hands or physical objects .e. Hairnets should be worn when cooking, preparing, or assembling food, such as stirring pots or assembling the ingredients of a salad .The FDA Food Code, 2022 documents Food Employees shall clean their hands and exposed portions of their arms immediately before engaging in food preparation including working with exposed food, clean equipment and utensils, and unpwrapped single-service and single-use articles and.(F) during food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks.</p> <p>Resident #2 was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE], with multiple diagnoses which included diabetes and anxiety.</p> <p>Resident #2's physician orders documented Basaglar KwikPen Subcutaneous Solution Pen-injection 100 Unit/ML (Insulin Glargine) inject 15 units subcutaneously.and Insulin Lispro Injection Solution 100 Unit/ML (Insulin Lispro) as per sliding scale.</p> <p>On 1/27/26 at 8:31 AM, observed LPN #1 place a syringe containing Glargine insulin on Resident #2's bed next to him as she cleaned the injection site. LPN #1 then picked up the syringe off the bed and administered the insulin to Resident #2.</p> <p>On 1/27/26 at 8:38 AM, LPN #1 stated she should not have placed the insulin syringe on Resident #2's bed.</p> <p>On 1/28/26 at 3:28 PM, the IP stated LPN #1 should have placed her resident medications on a protective cover on top of Resident #2's bedside table, not in his bed.</p> <p>On 1/28/26, the following was observed in the kitchen between 11:55 AM and 12:45 PM during meal service:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135140	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/28/2026
NAME OF PROVIDER OR SUPPLIER Madison Carriage Cove Short Stay Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 410 West 1st North Rexburg, ID 83440	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<ul style="list-style-type: none"> - The Kitchen Supervisor was observed leaving the tray line and going into the walk-in refrigerator and returning to the tray line to continue prepping plates without performing hand hygiene. - The Kitchen Supervisor was observed leaving the tray line and going into the dry-storage and returning to the tray line to continue prepping plates without performing hand hygiene. - Dietary Aide #1 was observed pureeing resident food items without performing hand hygiene. - Dietary Aide #2 was observed prepping plates from the tray line and placing them on the food cart. She was observed leaving the kitchen to deliver food trays to the residents and not performing hand hygiene when returning to the kitchen to prep more plates. - The FSM and Dietary Aide #2 had their hair pulled back into a ponytail and a baseball type hat on. The ponytails were hanging out of the back of the hat without being restrained by a hairnet. <p>On 1/28/26 at approximately 1:15 PM, the Kitchen Supervisor stated he was probably not seen washing his hands as much as he should have because one of the hand washing sinks was out of order.</p> <p>On 1/28/26, at approximately 1:20 PM, during an interview with the FSM, she stated she thought they did not have to wear hairnets if they wore a hat. She also stated the procedure for hand hygiene in the kitchen was to wash hands when visibly dirty and when changing tasks.</p>		