



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

REVISED COPY OF JULY 17, 2015, NOTICE

July 21, 2015

Kenneth Shull, Administrator
Idaho State Veterans Home - Lewiston
821 21st Avenue
Lewiston, ID 83501-6389

Provider #: 135133

Dear Mr. Shull:

On **July 2, 2015**, a survey was conducted at Idaho State Veterans Home - Lewiston 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 actual 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.) **Please provide ONLY ONE completion date for each federal and state tag (if applicable) in column (X5) Completion Date** to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.

After each deficiency has been answered and dated, the administrator should sign the Form

Kenneth Shull, Administrator
July 17, 2015
Page 2

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 **July 30, 2015**. Failure to submit an acceptable PoC by **July 30, 2015**, may result in the imposition of civil monetary penalties by **August 19, 2015**.

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*.

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. In addition, we are recommending that CMS impose the following remedy:

- A 'per instance' civil money penalty of \$1000.00

Kenneth Shull, Administrator
July 17, 2015
Page 3

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **January 2, 2016**, 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 David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 2; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

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

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

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

- BFS Letters (06/30/11)

[2001-10 Long Term Care Informal Dispute Resolution Process](#)
[2001-10 IDR Request Form](#)

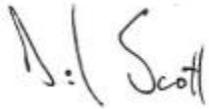
This request must be received by **July 30, 2015**. If your request for informal dispute resolution is received after **July 30, 2015**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, comments or concerns, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors,

Kenneth Shull, Administrator
July 17, 2015
Page 4

Long Term Care at (208) 334-6626, option 2.

Sincerely,

A handwritten signature in black ink that reads "D. Scott". The signature is written in a cursive style with a large initial "D" and a clear "Scott" following.

David Scott, RN, Supervisor
Long Term Care

DJS/dmj
Enclosures

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

PRINTED: 11/09/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135133	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/02/2015
NAME OF PROVIDER OR SUPPLIER IDAHO STATE VETERANS HOME - LEWISTON			STREET ADDRESS, CITY, STATE, ZIP CODE 821 21ST AVENUE LEWISTON, ID 83501	
(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 annual federal recertification survey of your facility. The surveyors conducting the survey were: Rebecca Thomas, RN, Team Coordinator, Linda Kelly, RN, and Becka Watkins, RN, The survey team entered the facility on June 28, 2015, and exited on July 2, 2015. Survey Definitions: ADL = Activities of Daily Living BIMS = Brief Interview for Mental Status cm = Centimeters CAA = Care Area Assessment CNA = Certified Nurse Aide DON = Director of Nursing LN = Licensed Nurse MAR = Medication Administration Record MDS = Minimum Data Set assessment PRN = As Needed RAI = Resident Assessment Instrument	F 000		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.	F 279		7/31/15

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

TITLE

(X6) DATE

Electronically Signed

08/04/2015

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 279	<p>Continued From page 1</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure a Vision Care Plan, triggered by the RAI process, was care planned as identified in the CAA. This was true for 1 of 9 (#2) residents sampled for the RAI process. This practice created the potential for harm due to the lack of direction in the care plan. Findings included:</p> <p>1. Resident #2 was originally admitted to the facility on 12/9/09, and readmitted on 1/16/15, with diagnoses of prostate cancer, hypertrophy of the prostate without urinary obstruction, Alzheimers Disease, and dementia with behavioral disturbances.</p> <p>The 5/1/15 Annual MDS Assessment documented the resident was severely cognitively impaired with a BIMS Score of 3 and required extensive assistance of at least one possibly more than two staff with ADLs. The Annual MDS Assessment documented the Vision Function Care Area triggered and was care planned.</p> <p>The 5/1/15 Care Area Assessment (CAA)</p>	F 279	<p>F 279 A facility must use the results of the assessment to develop, review and revise the residents comprehensive plan of care.</p> <p>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Resident #2 was affected by this deficient practice. His care plan will be audited by the MDS Coordinator to ensure issues identified in his CAA are care planned appropriately.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and actions that will be taken?</p> <p>Since all residents have the potential to be affected from this deficient practice, the MDS Coordinator or designee will audit the CAAs and care plans of all current</p>		

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F 279	Continued From page 2 Worksheet, completed with the annual assessment, documented in the Care Plan Considerations that the Visual Function Status would be addressed in the resident's care plan. The overall objective for the Visual Care plan was to minimize risks and to slow or minimize the resident's decline. The worksheet documented the resident had a diagnosis of dementia, which was a progressive disease, and further declines in vision were expected over time. Record review of the resident's care plan revealed a care plan was not developed for vision problems. On 7/1/15 at 2:25 PM, LN #2 stated, "I do not have a vision care plan." On 7/1/15 at 5:25 PM, the Administrator and DON were made aware of care plan concerns. The facility did not provide any further documentation.	F 279	residents to ensure that care areas that are triggered have been addressed in the plan of care. What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur? Root cause analyses showed that all triggered CAAs were not reviewed in a timely manner. All CAAs will be reviewed by the MDS review team weekly to ensure that all triggered care areas have been care planned as indicated. Any needed corrections will be made to ensure compliance. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? The RN Manager or designee will do random audits of CAAs and care plans. These audits will be done weekly for 30 days (x4), biweekly (x2) and then monthly (x1). All results will be reported to QA monthly (x3) to ensure compliance.		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical,	F 309		7/31/15	

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F 309	<p>Continued From page 3</p> <p>mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and record review, it was determined the facility failed to ensure compression hose were applied correctly for 1 of 2 sample residents (#6) with orders for compression hose. Resident #6 experienced increased bilateral knee pain when her compression hose rolled down and corded below her knees. Findings included:</p> <p>Resident #6 was admitted to the facility 6/9/14 with multiple diagnoses, including hereditary and idiopathic peripheral neuropathy, generalized osteoarthritis, and edema.</p> <p>The resident's Order Summary Report of Active Orders included, "Ted [sic - should read TED, thromboembolism-deterrent] Hose On in the AM off in the PM every day and evening shift for Edema." The order was started 2/4/15.</p> <p>On 6/29/15, Resident #6 was seated in the recliner next to her bed with her legs elevated on the recliner leg/foot rest. The resident moaned and complained of pain in both knees and showed the surveyor the compression hose on both of her legs. A deep indentation was observed below both knees, where the top of the hose had rolled down and created a corded effect. The resident said staff put the hose on her in the morning and that she wore them until bedtime. The resident said the hose were "really tight"</p>	F 309	<p>F 309 Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Resident #6 was affected by this deficient practice. TED hose were discontinued during the time of the survey, when the problem was first identified. Alternate orders for compression hose were put in place until appropriately sized compression hose could be obtained.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and actions that will be taken?</p> <p>All residents with current compression hose orders have the potential to be affected by this deficient practice. These residents will be assessed to ensure compression hose fit properly.</p>		

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F 309	<p>Continued From page 4</p> <p>below the knees and made already existing knee pain "a lot worse." The resident pointed to the rolled part of the hose and stated, "There's nothing you can do about it."</p> <p>On 6/30/15 at 10:20 a.m., LN #1 was asked if the resident wore compression hose. The LN stated, "Yes, if she wants them." The LN accompanied the surveyor into Resident #6's room, where the resident was in her recliner with her legs elevated on the leg/foot rest. The LN asked and received permission to look at the resident's legs. Compression hose were on both of the resident's legs, a deep indentation was noted below each knee where the hose had rolled down, and the resident complained of pain in both of her knees. The LN said the hose "may be to long" and she acknowledged that the rolled hose were corded below the resident's knees. The LN removed the hose and said she would "re-measure" the resident's legs and get a different pair of compression hose. The resident expressed relief when the hose were removed.</p> <p>Regarding applying antiembolitic elastic stockings, the 2013 Fundamentals of Nursing, eighth edition, by Potter and Perry, documented, "... measure patient's legs to determine proper stocking size ... Inspect stockings for wrinkles or constriction ... Inspect elastic stockings to determine that there are no wrinkles, rolls, or binding ..."</p> <p>On 7/2/15, the Administrator provided the following documentation regarding Resident #6: "It was noted ... on 6/30/15 ... compression hose that had 'rolled' below her knee. Compression stockings were removed and skin ... found to be blanch -able, no c/o [complaint of] pain, pedal pulses present. MD [physician] notified of indentation and compression hose being too long. New orders for comperm (tubi-grip G) to fit her</p>	F 309	<p>What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <p>Root cause analysis findings showed that not all staff were aware of how to correctly measure and assess for proper compression hose fit.</p> <p>RN Manager or designee will inservice Licensed staff on how to correctly measure and fit compression hoses. Licensed and unlicensed staff will be inserviced on how to correctly apply compression hoses.</p> <p>How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?</p> <p>RN Manager will do weekly audits of all residents with compression stockings to ensure proper fit and application, and do education as needed to ensure compliance.</p> <p>Audits will be completed weekly (x4), bi weekly (x2) and monthly (x1) and reported to QA monthly (x3).</p>		

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F 309	Continued From page 5 length (16 inches) for edema to lower extremities ..." The facility did not provide any other information which resolved the issue.	F 309			
F 315 SS=G	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility failed to ensure residents who were incontinent of urine received the care and services to improve their level of continence. This was true for 1 of 9 (#2) sampled residents. Resident #2 was harmed when he was found unresponsive and was hospitalized for a urinary tract infection. Findings included: 1. Resident #2 was originally admitted to the facility on 12/9/09, and readmitted on 1/16/15, with diagnoses of prostate cancer, hypertrophy of the prostate without urinary obstruction, and Alzheimer's Disease. The 1/3/14 Bowel and Bladder Incontinence care	F 315	F 315 Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?	7/31/15	

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F 315	<p>Continued From page 6</p> <p>plan, related to impaired mobility and Alzheimer's Disease, documented a goal, initiated 1/27/14, that the resident's risk for septicemia would be minimized/prevented via prompt recognition and treatment of symptoms of UTI.</p> <p>Interventions included: "**BLADDER RETRAINING PROGRAM: Offer, assist me to toilet upon my request, upon my rising and prior to bed, prior to and/or after my meals, Q [every] 4 hours at night and PRN upon my request," initiated 7/31/14; "**Establish voiding patterns," initiated 7/31/14; "**INCONTINENT: Check [often] and as required for incontinence. Wash, rinse and dry perineum. Change clothing PRN after incontinence episodes," initiated 1/27/14; "**Monitor/document for s/sx [signs and symptoms] UTI: pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp[erature], Urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns," initiated 1/27/14; and, "**Monitor/document/report PRN any possible causes of incontinence; bladder infection, constipation, loss of bladder tone, weakening of control muscles, decreased bladder capacity, diabetes, Stroke, medication side effects," initiated 2/17/14.</p> <p>NOTE: Resident #2's medical record did not include a bladder assessment prior to the 1/3/14 care plan.</p> <p>The 10/29/14 Quarterly MDS Assessment documented the resident was moderately cognitively impaired with a BIMS Score of 9, required extensive assistance of 1 person for toilet use, was frequently incontinent, and on a</p>	F 315	<p>Resident #2 was affected by this deficient practice. This resident will be reassessed for B&B and incontinence program.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and actions that will be taken?</p> <p>All residents have the potential to be affected by this deficient practice. Bowel & Bladder assessments will be done on all residents through the electronic medical records system. Residents that meet the criteria for the Bowel & Bladder program will immediately be placed on a restorative program.</p> <p>What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <p>Root cause analysis findings showed that nurses need more education on identifying signs and symptoms of UTIs. It was also identified that the facility was not using the B&B assessment in the electronic medical record. The RN Manager or designee will in-service the licensed staff on the signs and symptoms of UTIs and interventions for treatment.</p> <p>The RN Manager or designee will educate staff on the use of the Bowel & Bladder assessment in the facility's EMR system. Bowel and Bladder assessments will be done in conjunction with the MDS</p>		

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F 315	Continued From page 7 toileting program. A 12/11/14 Bowel and Bladder Screener for scheduled toileting documented the resident voided appropriately without incontinence, and was immobile or required the assistance of two staff members for toileting CNA charting for December 2014 Bladder Activity documented the resident was toileted at the following times: 12/1 - 2:24 a.m., 10:26 a.m., and 2:49 p.m. 12/2 - 1:38 a.m., 9:14 a.m., and 6:09 p.m. 12/3 - 1:59 p.m. 12/4 - 1:51 p.m. 12/5 - 9:34 a.m. 12/6 - 11:47 a.m. 12/7 - 1:59 p.m. 12/8 - 1:59 p.m. 12/9 - 9:47 a.m., and 3:05 p.m. 12/10 - 7:26 a.m., and 9:19 p.m. 12/11 - 3:18 a.m., 8:44 a.m., and 2:33 p.m. 12/12 - 1:35 a.m., 10:37 a.m., and 9:51 p.m. 12/13 - 3:00 a.m., 10:42 a.m., and 9:00 p.m. 12/14 - 5:42 a.m., 1:59 p.m., and 2:57 p.m. 12/15 - 3:15 a.m., 10:14 a.m., and 2:58 p.m. 12/16 - 10:46 a.m., 3:36 p.m., and 11:02 p.m. 12/17 - 3:15 a.m., 10:37 a.m., and 9:05 p.m. 12/18 - 2:43 a.m. 9:52 a.m. and 4:05 p.m. 12/19 - 1:48 a.m., 9:28 a.m. and 3:08 p.m. 12/20 - 3:37 a.m., 11:53 a.m., and 8:44 p.m. 12/21 - 2:40 a.m., 10:42 a.m., and 2:52 p.m. 12/22 - 12:07 a.m., 9:37 a.m., and 2:46 p.m. 12/23 - 3:34 a.m., 12:54 p.m., and 9:59 p.m. 12/24 - 12:26 a.m., 9:20 a.m., and 9:59 p.m. 12/25 - 4:31 a.m., 9:48 a.m., and 2:53 p.m. 12/26 - 12:06 a.m., 9:54 a.m., and 9:04 p.m. 12/27 - 3:39 a.m., 9:23 a.m., and 2:28 p.m. 12/28 - 5:56 a.m., 10:32 a.m., and 2:46 p.m.	F 315	schedule as well as with changes in condition. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? RN Manager or designee will do random questioning of licensed staff on signs and symptoms of UTIs to ensure staff is knowledgeable about identifying signs and symptoms. MDS coordinator or designee will conduct random audits to ensure Bowel & Bladder assessments have been done and interventions are in place. Audits will be completed weekly (x4), bi-weekly (x2), and monthly (x1). Report findings to QA monthly (x3).		

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

PRINTED: 11/09/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135133	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/02/2015
NAME OF PROVIDER OR SUPPLIER IDAHO STATE VETERANS HOME - LEWISTON			STREET ADDRESS, CITY, STATE, ZIP CODE 821 21ST AVENUE LEWISTON, ID 83501		
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F 315	<p>Continued From page 8</p> <p>12/29 - 5:59 a.m., 10:59 a.m., and 2:30 p.m. 12/20 - 5:33 a.m., 9:40 a.m., and 9:56 p.m. 12:31 - 5:45 a.m. and 10:10 a.m.</p> <p>NOTE: Record review revealed the resident was admitted to a local hospital from 12/2/14 to 12/10/14, yet the facility continued to document that staff toileted the resident during that period.</p> <p>CNA charting for January 2015 Bladder Activity documented the resident was toileted at the following times:</p> <p>1/1 - 1:01 a.m., 9:49 a.m., and 6:06 p.m. 1/2 - 5:38 a.m., 11:45 a.m., and 9:31 p.m. 1/3 - 1:06 a.m., 9:47 a.m., and 3:27 p.m. 1/4 - 2:54 a.m., 10:45 a.m., and 3:05 p.m. 1/5 - 5:54 a.m., 1:59 p.m., and 2:14 p.m. 1/6 - 3:41 a.m., 1:59 p.m., and 3:51 p.m. 1/7 - 2:04 a.m., 11:48 a.m., and 9:59 p.m. 1/8 - 5:55 a.m., 10:10 a.m., and 9:59 p.m. 1/9 - 12:12 a.m., 9:14 a.m., and 9:59 p.m. 1/10 - 5:59 a.m., 9:26 a.m., and 9:59 p.m. 1/11 - 4:34 a.m., 10:44 a.m., and 2:49 p.m. 1/12 - 2:51 a.m., 10:20 a.m., and 9:59 p.m. 1/13 - 2:17 a.m., 11:07 a.m., and 3:17 p.m. 1/14 - 4:50 a.m., 10:29 a.m., and 9:59 p.m. 1/15 - 3:26 a.m., 11:07 a.m., and 2:46 p.m. 1/16 - 5:32 a.m., 1:59 p.m., and 9:59 p.m.</p> <p>NOTE: Record review revealed the resident was admitted to a local hospital from 1/14/15 to 1/16/15, yet the facility continued to document that staff toileted the resident during that period.</p> <p>A Progress Note [PN], dated 1/14/15 at 6:15 PM, documented, "Resident nonresponsive skin pale very warm to touch, temporal T-100.2, BP [Blood Pressure] 110/58, AP [Apical Pulse] 102, R [Respirations] 36, shallow and labored,</p>	F 315			

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F 315	<p>Continued From page 9</p> <p>diminished sounds bilateral upper lobes, absent bilateral lower lobes. Sp O2 [saturation of oxygen] 88% @ [at] 2 lpm [liters per minute] increased to 3 lpm, no change in saturation. MD notified, sent to ER [Emergency Room] as in 'POST' [Physician Orders For Scope of Treatment]. Message left with family to call facility. Non-emergent EMS notified and transfer to [a local hospital] ER for further evaluation @ 1830 [6:30 PM]."</p> <p>NOTE: No progress note was found in the facility medical record which indicated the resident had been monitored for s/sx of a urinary tract infection as directed in the bladder incontinence care plan initiated on 1/27/14.</p> <p>A PN, dated 1/14/15 at 11:25 PM, documented, "Resident admitted to the Med/Sug. [sic] floor for the Dx. [Diagnosis] of UTI and for IV [Intravenous] ABO [antibiotic] therapy."</p> <p>The History and Physical, from a local hospital, dated 1/15/15, documented, "In the Emergency Department, the patient initially was unresponsive ... He has been brought to this facility multiple times for altered mental status and many times it is related to urinary tract infection. As a result, the patient in the Emergency Department was started on Ceftriaxone for urinary tract infection."</p> <p>The Discharge Summary from a local hospital, dated 1/16/15, documented the following primary discharge diagnoses: "1. Altered mental status due to urinary tract infection (complicated); and, 2. Urinary tract infection due to Proteus mirabilis in the setting of benign prostatic hypertrophy, but no overt urinary retention here." The Discharge Summary further documented, "In</p>	F 315			

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F 315	<p>Continued From page 10</p> <p>brief, the patient came in with a decreased level of consciousness and altered mental status compared to his baseline. He was evaluated in the Emergency Room, had frank pyuria (presence of white blood cells or pus in the urine) and was placed on broad spectrum antibiotics ... His urine culture the following day showed swarming proteus and so I changed to Levofloxacin ... to Rocephin. The patient showed significant improvement in the past 24 hours with mental status returning to baseline. No fevers ... The patient will be discharged with seven additional days of Cefuroxime 500 MG by mouth two times a day."</p> <p>Record review revealed the first Bowel and Bladder assessment was dated 2/17/15 and documented the resident had gradual onset of bladder incontinence, which was stable with a 1-2 year history of duration. The voiding pattern section was left blank for the question of how frequently the resident toileted on average each day. For the symptoms of overflow incontinence, the assessment documented, "unknown." For the question, "Do you feel that you completely empty your bladder when you pass urine," the assessment documented the following:</p> <ul style="list-style-type: none"> *Occasional urge incontinence and could hold urine for 5 minutes after feeling the first urge; *Occasionally was aware of the urge to void, of urine being passed, and trouble starting to pass urine; *Not aware of being wet; *Voiding record had not been initiated; and, *Type of bladder incontinence was listed as "Functional" (Functional incontinence is defined as when a person does not recognize the need to void or does not recognize where the toilet is located). 	F 315			

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F 315	<p>Continued From page 11</p> <p>*Contributing factors included weight, cognition, medications, and mobility.</p> <p>On 6/29/15 at 10:05 AM, Resident #2 was observed in bed sleeping when two staff members came in and assisted the resident to move up in bed. Staff were not observed to check the resident's brief. The resident was observed sleeping in bed at 11:00 AM and 1:30 PM. At 2:30 PM, LN #2 was observed as she came into the room, checked the resident's brief, which was dry, and transferred the resident to his wheelchair with the assistance of another staff member.</p> <p>On 6/30/15 at 2:00 PM, Resident #2 stated he remembered a time when he asked for help to the toilet and staff did not get back to him for 1-1/2 hours. He stated, "It only happened one time but it made me feel like an idiot."</p> <p>On 7/1/15 at 2:25 PM, LN #2 was asked to explain the Bladder Retraining Program intervention. She stated the resident should be offered toileting before and after meals, upon rising and before bedtime. LN #2 stated, "We don't have a check and change program. When asked for the resident's established voiding program, as care planned 7/31/14, LN #2 stated, "I do not see an assessment." When asked about the INCONTINENT intervention and what check often meant, as care planned 1/27/14, LN #2 stated "check often" meant at least every two hours. LN #2 was then asked how often incontinence care was provided and where it was documented. She stated, "At least every 2 hours and PRN, I'll look at our Bladder Policy." When asked to explain the resident's UTI history, LN #2 stated the resident did not have a strong history of UTI's and that 1/14/15 was his first UTI and his</p>	F 315			

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F 315	<p>Continued From page 12</p> <p>second UTI was 6/6/15. She stated the resident had overflow incontinence due to BPH (Benign Prostate Hypertrophy) and functional incontinence. LN #2 provided a copy of the Policy and Procedure (P&P) for Perineal Care, which documented perineal care should be given each morning and evening and more frequently if needed. At this time, the DON joined the conversation for review of the policy, which documented, "All residents wearing continent briefs would be checked for need of changing." When asked how often a resident would be checked, the DON stated, "As often as they need it, I don't see the problem."</p> <p>On 7/2/15 at 7:35 AM, LN #2 stated, "Bladder Assessments are like Safety Assessments. The outcome is what is important, not to have an unavoidable decline in bladder incontinence. How we get there is facility based, so I may not always have a Bladder Assessment unless he's had a decline in bladder continency." When asked how the facility measured the decline in continence, LN #2 stated, "By the MDS, then we do a bladder assessment if they had a decline in continence." When asked how the facility assessed bladder declines for a resident with bladder cancer, BPH or retention, LN #2 stated, "We don't measure, we keep track of urine output. We chart daily on urinary output in PCC (Point Click Care), there is nothing that says you have to measure." When asked how the facility evaluated declines in bladder continency, LN #2 stated, "Every week I pull a significant change report that shows any declines in daily living or continency. This report goes to the Restorative Nurse and she interprets the report and completes assessments as needed."</p>	F 315			

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F 315	<p>Continued From page 13</p> <p>On 7/2/15 at 10:00 AM, LN #2 stated, "At one time, we decided to do a Bowel and Bladder Assessment on everybody in the building after noticing on the Quality Assurance that we were getting close to threshold for bladder continency." She provided a copy of the 2/17/15 Bowel and Bladder Assessment for Resident #2 and stated, "I don't know there was a Bladder Assessment done before that time." LN #2 stated she found a 12/11/14 Bowel and Bladder Screener that included a category, "Candidate for Schedule Toileting," (timed voiding), however this section did not include a documented outcome. When asked what was done for the resident after the 12/11/14 assessment, LN #2 stated, "I don't have a nurse's note pertaining to the bladder screener done on 12/11/14." When asked for the policy and procedure for the Bladder Training Program, LN #2 stated, "I don't know if there is a P&P." When asked about the Bladder Retraining Program as care planned on 7/31/14, LN #2 stated, "There is retraining and something to help them maintain continency without further declines. A cognitive person can do a Retraining Program, [Resident #2] cannot." When shown the 7/31/14 care plan intervention, LN #2 stated, "It shouldn't say bladder retraining, it should say prompted voiding. I wrote that wrong."</p> <p>On 7/2/15 at 10:40 AM, LN #2 provided a copy of the Bladder Assessment and Retraining Policy and Procedure, which documented, "Bowel and Bladder screening will be completed on each resident within seven days of admission, quarterly and on any resident identified as having a change in continence status which would benefit from further assessment ... results of this assessment shall be included in the care plan as appropriate." Additionally, the policy documented, "Once the</p>	F 315			

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F 315	<p>Continued From page 14</p> <p>decision is made for bladder retraining the Restorative Nurse will implement the retraining program for 30 days. Each week the Restorative Nurse will document progress, or lack thereof in the progress notes. If the resident is unable to show progress in a 30 day period then discontinue the program. The Restorative Nurse will make recommendations for staff to follow such as routine toileting program, to take to bathroom upon rising, before meals, after meals and at bedtime and PRN."</p> <p>Resident #2 was harmed when the facility: *Failed to recognize the resident had a history of UTI's, and had been hospitalized multiple times for altered mental status related to UTI's, as documented in a local hospital's History and Physical; *Failed to follow its policy and procedure to complete quarterly assessments or complete a bladder assessment when the resident experienced a change in continence status, such as after being hospitalized for a UTI; *Annual and Quarterly MDS assessments documented the resident was on a toileting program, however the facility failed to follow its policy and procedure for Bladder Retraining, and did not document the resident's progress or lack thereof. In addition, LN#2 stated the resident should have been on a prompted voiding schedule due to his cognitive status; *Failed to establish a voiding pattern as care planned; *Failed to check often for incontinence as care planned and failed to check the resident for toileting needs every 2 hours or PRN; *Failed to monitor for s/sx of UTI's as care planned. The resident presented to a local hospital Emergency Room with frank pyuria, was</p>	F 315			

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F 315	Continued From page 15 hospitalized, and required IV antibiotic therapy after he was found unresponsive in bed with an elevated temperature and respiration rate.	F 315			
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record review, it was determined the facility failed to assess 4 of 9 sample residents (#s 6, 7, 8 and 9) to determine whether the individual residents were safe using bed side rails, which can increase resident safety risk, including entrapment, and create the potential for more than minimal harm. Findings included: 1. Resident #6 was admitted to the facility 6/9/14 with multiple diagnoses, including hereditary and idiopathic peripheral neuropathy, generalized osteoarthritis, anxiety, bipolar disorder, vascular dementia with delirium, obsessive-compulsive disorders, and edema. The resident's 5/20/15 quarterly MDS assessment coded a BIMS score of 14 (intact cognition) and extensive 1-person assistance for bed mobility.	F 323	F 323 The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Residents #6, 7, 8 and 9 were affected by this deficient practice. These residents will be assessed for safe use of quarter side rails/transfer bars. How will you identify other residents having the potential to be affected by the same deficient practice and actions that will be taken?	7/31/15	

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F 323	<p>Continued From page 16</p> <p>The resident's care plan documented, "I require limited, to extensive, assistance in most care areas." It was initiated 6/12/14.</p> <p>Interventions for this Focus area included, "Bed Mobility: The resident uses bilateral 1/4 rails to maximize independence with turning and repositioning in bed," initiated/ revised 6/20/14; and, "Bed Mobility: The resident requires assistance by 1-2 staff to turn and reposition in bed uses bilateral 1/4 rails to assist with bed mobility," initiated 6/20/14 and revised 9/12/14.</p> <p>The bilateral 1/4 side rails were observed in the raised position on the resident's bed on 6/28/15 during the initial tour of the facility; 6/29/15 at 11:55 a.m., 1:15 p.m., 1:50 p.m., and 3:10 p.m.; and 6/30/15 at 9:25 a.m., 10:16 a.m., 2:10 p.m., 3:00 p.m., and 4:05 p.m.</p> <p>On 7/1/15 at 3:30 p.m., the DNS and Interim Nurse Manager were interviewed about the side rails on the resident's bed. They were asked to provide evidence the side rails had been determined as safe for the resident to use. The DNS stated, "We don't do side rail assessments because the RAI manual does not consider them a restraint. We only use 1/4 side rails or transfer bars, like bed canes."</p> <p>On 7/1/15 at 4:30 p.m., the DNS and Interim Nurse Manager returned to the surveyor's workroom. The DNS stated, "We don't evaluate safety with wheelchair use. We determine they [side rails] are safe but we don't have a form per se. But we don't put them [side rails] up unless we deem them safe." When asked to provide documented evidence the side rails were "deemed" safe for the resident, the DNS indicated</p>	F 323	<p>All residents have the potential to be affected by this deficient practice. All residents will be assessed for side rail/transfer bar safety by using the Safety assessment in the EMR system.</p> <p>What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <p>Root cause analysis findings showed that residents had been assessed, but the assessments did not identify clearly that the residents were safe to have bedside rails or positioning devices.</p> <p>Safety assessments will be done on all residents in conjunction with the MDS assessment schedule and PRN. The RN Manager or designee will educate licensed staff on the use of the new EMR assessment for restraints/adaptive equipment. DON, RN Manager and nursing leadership team will review all findings resulting from residents' assessments and put the proper interventions into place.</p> <p>How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?</p> <p>RN Manager or designee will monitor that proper interventions are in place and make corrections and provide education as needed. MDS Coordinator or designee</p>		

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F 323	<p>Continued From page 17</p> <p>there was no safety assessment documentation directly related to individual resident's use of side rails.</p> <p>On 7/2/15 at 7:35 a.m., the DNS provided a single page, undated and unsigned, type written document titled Side Rail Assessments which documented:</p> <p>"Review of F-tag 323 does not include verbage [sic] that indicates that a specific assessment for safety with transfer bars/side rails is required. Residents' transfer status and bed mobility as well as their general medical condition is reviewed quarterly as well as PRN by the inter-disciplinary team. Included in this review is a review of their safe use with side rails. If the review indicates that a resident is no longer safe or able to utilize these devices they are removed. Any incidents that occur in our facility are reviewed through the risk management process as well as the safety committee and the QA [Quality Assurance] committee. Up to this date, the facility has not had any incidents or negative outcomes associated with the use of side rails or transfer bars. The QA audit on side rails/transfer bars indicated that side rail usage was appropriate and no negative outcomes had occurred. The QA committee determined that no changes were needed to the facilities [sic] current processes and no changes were needed. The QA committee continues to monitor that facility's processes. Not all resident in our facility have side rails/transfer bars as you have observed. They are only in use when indicated and deemed safe by the inter-disciplinary team. Once their use has been deemed to be indicated to promote independence with mobility and transfers, they are care planned. In speaking with the Survey Team member, the verbage [sic] of 'side rail</p>	F 323	<p>will conduct random audits to ensure these assessments are completed as scheduled.</p> <p>Audits will be completed weekly (x4), bi-weekly (x2), and monthly (x1). Report findings to QA monthly (x3).</p>		

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

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OMB NO. 0938-0391

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F 323	<p>Continued From page 18</p> <p>assessment' was used. There is no direct language included in F-323 requiring the specific use of such language/assessment. The facility has shown through our lack of negative outcomes or incidents associated with the use of side rails that our processes, protocols, various committees and systems meet the intent of F-323."</p> <p>The facility did not provide documented evidence of the "review" of the resident's safe use with side rails or that the side rails had been "deemed" safe by the inter-disciplinary team.</p> <p>2. Resident #7 was admitted to the facility 6/5/14 with multiple diagnoses, including aftercare for healing traumatic fracture of hip, hip joint replacement, generalized osteoarthritis, paralysis agitans (Parkinson's disease), muscle weakness, lack of coordination, stiffness of joints, reactive confusion, nonpsychotic mental disorder, adjustment disorder with anxiety, and dementia with behavioral disturbances.</p> <p>The resident's 6/2/15 annual MDS assessment coded a BIMS score of 9 (moderate cognitive impairment) and extensive 2-person assistance for bed mobility.</p> <p>The resident's care plan documented, "I require extensive, assistance in most care areas r/t [related to] Dementia, Limited ROM [range of motion], Activity Intolerance, Limited Mobility, PARKINSONS, [and] Impaired balance," initiated 6/6/14 and revised 3/5/15.</p> <p>Interventions for this Focus area included: "Bed Mobility: The resident uses bilateral 1/4 rails to maximize independence with turning and repositioning in bed." Initiated and revised</p>	F 323			

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F 323	<p>Continued From page 19 6/13/14.</p> <p>The resident was observed on his bed with the bilateral 1/4 side rails in the raised position on 6/29/15 at 1:40 p.m. and 3:25 p.m. and 6/30/15 at 2:15 p.m.</p> <p>On 7/1/15 at 3:25 p.m., the DNS and Interim Nurse Manager were interviewed about the side rails on the resident's bed. They were asked to provide evidence the side rails had been assessed to determine if they were safe for the resident to use. The DNS stated, "We don't do side rail assessments because the RAI manual does not consider them a restraint. We only use 1/4 side rails or transfer bars, like bed canes."</p> <p>Refer to example 1 regarding follow-up interviews with staff on 7/1 and 7/2/15.</p> <p>3. Resident #8 was admitted to the facility on 6/1/11 with multiple diagnoses, including chronic airway obstruction, pneumonia, and osteoarthritis.</p> <p>The most recent Annual MDS Assessment, dated 1/12/15, documented the resident was cognitively intact with a BIMS Score of 14, and needed extensive assistance with the support of at least two staff for bed mobility and transfers. The resident was not steady and only able to stabilize with staff assistance when moving from a seated to standing position, moving on and off the toilet, and surface-to-surface transfer between bed and chair or wheelchair. Additionally, the resident had range of motion limitation bilaterally for her lower extremities, which interfered with her daily functions or placed the resident at risk of injury.</p>	F 323			

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F 323	<p>Continued From page 20</p> <p>The most recent Quarterly MDS Assessment, dated 6/29/15, documented the resident was cognitively intact with a BIMS Score of 15, needed extensive assistance with the support of 1 staff for bed mobility, and needed extensive assistance with the support of at least two staff for transfers. The resident was not steady and only able to stabilize with staff assistance when moving from a seated to standing position, moving on and off the toilet and surface-to-surface transfer between bed and chair or wheelchair. Additionally, the resident had range of motion limitation bilaterally for her lower extremities, which interfered with her daily functions or placed the resident at risk of injury.</p> <p>The Care Area Assessment (CAA) Worksheet, dated 1/12/15, documented Resident #8 had bilateral foot drop and wanted to maintain and improve her upper extremity strength. Under Care Plan Considerations, the worksheet documented, "Will proceed to care plan for ways to maintain upper extremity movement, and slow declines in lower body mobility, and avoid complications related to her decreased mobility of her lower extremities."</p> <p>Resident #8's ADL care plan documented, "I require extensive assistance in most care areas r/t [related to] limited ROM [range of motion], Fatigue, Activity, Intolerance, Limited Mobility, SOB [shortness of breath], Impaired balance, initiated 1/3/14." An intervention for bed mobility documented, "The resident uses bilateral 1/4 rails to maximize independence with turning and repositioning in bed."</p> <p>On 6/29/15 at 9:57 AM, 10:55 AM, 1:25 PM, 1:45</p>	F 323			

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F 323	<p>Continued From page 21</p> <p>PM, 2:45 PM, 3:30 PM, and throughout the survey process, Resident #8's side rails were observed to be in the upraised position bilaterally.</p> <p>On 7/1/15 at 2:25 PM, LN #2 stated the facility did not have side rail assessments because the device was not considered a restraint. She then provided a copy of the P0100 Physical Restraint MDS Guideline which documented, "While the bed rails may not constitute a physical restraint, they may affect the resident's quality of life and create an accident hazard."</p> <p>4. Resident #9 was originally admitted to the facility on 12/11/12, and readmitted on 5/28/15, with multiple diagnoses, including sepsis, Methicillin Resistant Staphylococcus Aureus [MRSA], paraplegia, and muscular wasting and disuse atrophy.</p> <p>The most recent Significant Change MDS Assessment, dated 1/23/15, documented the resident was cognitively intact with a BIMS Score of 15, needed extensive assistance with the support of at least two staff for bed mobility, and was totally dependent on staff for transfers. The resident had functional limitations in range of motion with bilateral impairment of his lower extremities.</p> <p>The most recent Quarterly MDS Assessment, dated 4/24/15, documented the resident was cognitively intact with a BIMS Score of 15, needed extensive assistance with the support of at least two staff for bed mobility, and was totally dependent on staff for transfers. The resident had functional limitations in range of motion with bilateral impairment of his lower extremities.</p>	F 323			

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F 323	Continued From page 22 Resident #9's ADL care plan, initiated 1/13/14, documented, "The resident has limited Mobility in lower extremities due to post polio syndrome with paralysis of lower extremities." An intervention, dated 3/4/14, documented, "Resident has bilateral 1/4 rails on bed to assist with bed mobility." On 6/29/15 at 9:55 AM, 10:50 AM, 1:25 PM, 2:25 PM, 3:28 PM, and throughout the survey process, Resident #9's side rails were observed to be in the upraised position bilaterally. On 7/1/15 at 4:10 PM, LN #2 stated the facility did not consider side rails a restraint and did not have safety assessments.	F 323			
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical	F 329		7/31/15	

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F 329	<p>Continued From page 23</p> <p>record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure residents were free from unnecessary medications. This was true for 1 of 9 residents (#9) sampled for gradual dose reductions. This created the potential for harm as unnecessary drugs can lead to adverse reactions and health decline. Findings included:</p> <p>Resident #9 was admitted to the facility on 12/11/12, and readmitted on 5/28/15, with multiple diagnoses including sepsis, Methicillin Resistant Staphylococcus Aureus [MRSA], paraplegia and muscular wasting and disuse atrophy.</p> <p>The most recent Significant Change MDS Assessment, dated 1/23/15, documented the resident was cognitively intact with a BIMS Score of 15, had symptoms of depression 2-6 days per week, did not have behaviors, but did reject care, which occurred 1-3 days per week.</p> <p>The most recent Quarterly MDS Assessment, dated 4/24/15, documented the resident was cognitively intact with a BIMS Score of 15, did not have symptoms of depression, behaviors or rejection of care.</p>	F 329	<p>F 329 Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Resident #9 was affected by this deficient practice. Resident's medication regimen has been reviewed by his primary physician, as well as the facility's Medical Director. Their reviews showed no GDR indicated and risk versus benefits were addressed.</p> <p>How will you identify other residents having the potential to be affected by the</p>		

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F 329	Continued From page 24 The June 2015 Order Summary Report, (Recapitulation Orders), documented the following order for the diagnosis of depression, "PARoxetine HCl [Paxil] Tablet 20 MG, Give 1 tablet by mouth in the morning," with an order date of 5/28/15. On 7/1/15 at 5:40, LSW #3 stated the resident had been receiving Paxil for more than a year. She stated the facility reviewed medications quarterly and Resident #9's last medication review was 10/26/14. She provided a copy of the Quarterly Mood/Behavior Medication Review (QMBMR) and stated, "At that time, our committee recommended no changes." When asked if there was physician documentation of the clinical rational for why an attempted dose reduction was contraindicated, LSW #3 stated, "It should have been listed in the committee recommendations, but it isn't." Record review of the QMBMR form provided by LSW #3 documented, "A 1. GDR contraindicated? No." Additionally, the QMBMR documented the initial start date of Paxil 20 MG was 5/16/13. On 7/1/15 at 5:25 PM, the Administrator and DON were made aware of the gradual dose reduction concern. No further information was provided by the facility.	F 329	same deficient practice and actions that will be taken? All residents taking psychotropic drugs have the potential to be affected by this deficient practice. These residents are reviewed quarterly by the QMBMR (Quarterly Mood/Behavior Medication Review) Committee. This committee includes representatives from Social Services, RN, Pharmacist, Medical Director and Psychiatrist as needed. Social Services will audit all residents currently on psychotropic medication to ensure that GDR assessments have been completed and are current and that risk versus benefits of these medications have been reviewed. What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur? Root cause analysis findings showed that resident had been reviewed by the QMBMR committee. At that time the committee determined that no GDR was indicated, but no note specifically addressing that a GDR was not indicated or that risk versus benefits had been addressed was included in their documentation. This was corrected at the time of the survey. The QMBMR, will meet monthly to review GDRs and psychotropic medication management. Specific diagnoses,		

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F 329	Continued From page 25	F 329	targeted behaviors and risk versus benefits associated with these meds will also be addressed by this committee. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? Social Services will audit random charts to ensure GDRs are in-place and current. Social Services will audit residents on psychotropic medications and ensure that documentation regarding risk versus benefits is in place. Social Services will maintain an attendance log for each meeting. Audits will be completed weekly (x4), bi-weekly (x2), and monthly (x1) and report findings to QA monthly (x3).		
F 353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this	F 353		7/31/15	

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F 353	<p>Continued From page 26 section, licensed nurses and other nursing personnel.</p> <p>Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>This REQUIREMENT is not met as evidenced by: Based on review of the Three-Week Nursing Schedule, Resident Council meeting minutes, Grievance Forms, Family Survey Form, Resident Group interview, and individual resident interview, it was determined the facility consistently failed to ensure there was adequate staffing to answer call lights in a timely manner and provide for the needs and well-being of residents. This affected 6 of 15 sampled residents (#s 2, 7, 9-11, & 13) and 8 of 20 residents who attended the group interview. Additionally, staffing shortages had the potential to affect all other residents who lived in the facility and who required staff assistance with their ADLs. This failure created the potential for residents in the facility to experience psychosocial and physical harm. Findings included:</p> <p>1. On 6/29/15 the facility provided a list of 18 residents who required ADL assistance by two staff - Resident #s 2, 7, 9-11 & 13, as well as 12 random residents.</p> <p>When the Three-Week Nursing Schedule was reviewed, it was determined the facility did not meet the State requirement for registered professional nurse (RN) coverage when the resident occupancy rate was between 60 and 89 residents for each of the days reviewed.</p>	F 353	<p>F 353 The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:</p> <p>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Residents #2, 7, 9, 10, 11, and 13 were affected by this deficient practice. The DNS and RN Manager reviewed staffing for licensed and un-licensed staff and modified staffing patterns for all three shifts and moved staff according to the needs of the residents. Additional staff have been hired to ensure adequate licensed and un-licensed staff are available to provide ADL's as well as</p>		

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F 353	<p>Continued From page 27</p> <p>Additionally, the facility did not meet the minimum staffing requirement of 2.4 hours per resident per day. (Please see C-762 as it relates to staffing). The Three-Week Nursing Schedule documented there were 7 of 21 days when only 1 RN and 2 CNA's worked the night shift for 63-64 residents. The night staff would not be able to respond to call lights, toilet, and turn and reposition residents who needed the assistance of two staff every two hours with this minimum staffing.</p> <p>2. a) Resident Council meeting minutes for April, May, and June 2015 were reviewed and included the following documentation: * April 7: "New Business: ... Resident expressed concern about not having enough showers since living here. * June 2: "New Business: ... Residents also remarked that there can be long wait times before meals are served out.</p> <p>b) Suggestion/Grievance Forms for July 2014 through June 2015 were reviewed and included the following documentation: * 8/1/14 Resident reported to nurse who reported to Social Services - "... Rst [resident] ... yells out when her call light not answered within a couple minutes." Investigation: "... no [increased] anxiety/restlessness/yelling. Reviewed call light sheets ..." Resolution: "Senior RN educating staff on answering call lights." * 8/12/14 Resident in Resident Council - "Why is it when a resident asks to go to bathroom they are left sitting around over 15 minutes. They need more help. (of note, many residents in counal [sic] agreed & voiced agreement)." Investigation: "Nursing - (no other documentation)." Resolution: "Without a specific incident and information ...</p>	F 353	<p>meeting mandatory PPD requirements.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and actions that will be taken?</p> <p>All residents have the potential to be affected by the deficient practice. The DON and RN Manager will review staffing for licensed and un-licensed staff and modify staffing patterns to ensure the needs of the facility's residents are being met as well as meeting mandatory PPD requirements.</p> <p>What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <p>Root Cause Analysis findings showed that the number of staff was adequate, but identified additional needs of more staff members on different shifts.</p> <p>The DNS and RN Manager reviewed staffing for licensed and un-licensed staff and modified staffing patterns for all three shifts and moved staff according to the needs of the residents. Additional staff have been hired to ensure adequate licensed and un-licensed staff are available to provide ADL's as well as meeting mandatory PPD requirements.</p> <p>How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance</p>		

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F 353	Continued From page 28 difficult to answer concern ... contact staff on-duty ... if a problem arises." * 8/14/14 Family survey and residents - "... staff tell the resident that they will get back [with] them and then not return." Investigation: "Nursing - (no other documentation)." Resolution: "Without specific information, difficult to answer concern. If ... continues, contact the charge nurse or Senior RN at the time incident occurs [sic]." * 8/14/14 Family survey - "Feels it takes staff too long to answer call lights." Investigation: "Nursing - ... being tracked by current call bell system." Resolution: "Nursing is auditing the call bell response times ... There have been times due to thunderstorms, the system has gone inoperative..." * 8/14/14 Family survey - "Feel we need more staffing." Investigation: blank. Resolution: "Currently staffing levels are full." * 8/14/14 Family survey - "Felt that staff didn't respond to assistance [sic] needed in rest room's [sic] fast enough." Investigation: "Nursing - Duplicate." Resolution: blank. * 8/14/14 Resident reported to Social Services - "Sometimes is in the bathroom a long time before staff come in to asst [assist] him." Investigation: "Staff indicate [resident's name] will take self to bathrm [sic]-even though he should have staff asst - he'll be in bathrom [sic] & Staff doesn't know." Resolution: "Ombudsman...visited w/ him 8/13 noting no concerns/issues. Reminded [resident's name] to use call lights for asst [assistance]. Educated staff, f/u [follow up] [with] LN on floor." * 8/15/15 Resident reported to Social Services - "Wants to discuss & know why shower aid is no longer doing showers. [Resident's name] states he did ask admin[istrator] ... told this couldn't be discussed. ... D/T [due to] personnel issues ..."	F 353	program will be put into place? RN Manager or designee will review and modify staffing patterns of licensed and un-licensed staff for all shifts. The RN Manager or designee will monitor hours worked to ensure compliance of Federal and State requirements. Social Services, RN Manager or designee will ensure residents' needs are being met and staffing is in compliance to meet those needs by monitoring Grievance forms r/t resident needs and ensure resident concerns are decreasing and needs are being met. Call light times will also be monitored to ensure they are beng answered in a timely manner. RN Manager or designee will conduct audits to ensure staffing patterns meet the needs of the residents and comply with Federal and State requirements. Audits will be completed weekly (x4), biweekly (x2), monthly (x1) and report findings to QA monthly (x3).		

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

PRINTED: 11/09/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135133	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/02/2015
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F 353	Continued From page 29 Investigation: "Administrator & Nsg [nursing] reviewed [with] [resident's name] ..." Resolution: SW [social worker] explained personnel issues ... [Resident' name] would like to speak w/ ...Ombudsman...on her next visit." * 9/11/14 Resident reported - "Waited for 7 hr [hours] before call light was answered." Investigation: "... Call light log was reviewed ..." Resolution: "No call light registered on log for greater than 14 minutes and 42 seconds. Will discuss with nursing staff. On-going audit for call lights completed monthly." * 10/3/14 Resident reported to Social Services - "[CNA's name] was helping [resident's name] get settled into bed when CNA had to leave suddenly d/t [due to] alarm going off w/ another rst [resident]. CNA never returned & [resident's name] thinks it was 3/4 hr before another CNA came to help him ..." Investigation: "Explained to [resident's name] ea[ch] rst has own needs & he would not be left if not safe, staff are caring for several rsts [residents]. Call light log attached for time period ... Resolution: [Resident's name] also acknowledges should staff leave his rm he's never been in an unsafe situation or dignity issues." * 10/14/14 Family reported to Nursing - "Son ... stated his mother had called him and was complaining she had to use the bathroom and nobody would help her. She reports she wet herself." Investigation: "Staff notes show aids attempting to help [resident's name] but she denied the help and told them to get out of the room. Staff were eventually able to help [resident's name] ..." Resolution: "Son understood ... wanted to convey her concerns." * 10/17/14 Family reported to nurse - "... [resident's name] tells me that she calls the 'night' nurses to go potty and by the time the [sic] come,	F 353			

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F 353	<p>Continued From page 30</p> <p>Grandma could not hold it and goes where her clothes and bed have to be changed all night long. She says always 20 mins. [minutes] or longer and the nurses get mad at her."</p> <p>Investigation: "... call light registered was reviewed ... There was one call at 19:29 [minutes] at 0533 [5:33 a.m.], and aid [sic]/nurse getting others up, answer other call bells." Resolution: "... review with floor nurses and CNA staff to be more cognizant of call bell initiation ... Call bells are audited weekly..."</p> <p>* 11/5/14 Family reported - "Believes her mom was left in bed all afternoon and then found to be wet with urine." Investigation: [Administrator's name] asked that if ... like this again to please contact him directly." Resolution: "[Family] was happy with this ..."</p> <p>* 4/7/15 Resident in Resident Council - "[Resident's name] is concerned about showers. He estimates he has had about 6 showers or so since he's lived here. He is unaware of what days his showers should be on." Investigation: "BIMS = 15/15 [intact cognition] Baths completed 3/11, 3/13, 3/17, 3/25 [8 days later], 3/28, 4/1, 4/4." Resolution: "Shower staff informed resident about his bath days. Audit to be completed ..."</p> <p>* 5/6/15 Resident reported to staff - "Stated he and another resident had to wait over 60 minutes for a meal." Investigation: "... [Resident's name] stated he had come in earlier than usual ... and it wasn't really quite an hour late. But, he did say staff had apologized [illegible] as something had delayed them ..." Resolution: Thanked for conversation.</p> <p>* 5/7/15 Family Report - "... (3) Staff leave [resident's name] in the bathrm [bathroom] alone (4) Call lights go unanswered 30 minutes or longer ..." Investigation: "...[Resident's name] is (I) [independent] w/ transfers not needing assist ..."</p>	F 353			

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F 353	<p>Continued From page 31</p> <p>Call lights monitored - noted not to be 30 minutes ..." Resolution: "Multiple emails and discussions between family & staff ..."</p> <p>* 5/22/15 Resident reported to SW - "Dinner serve out last eve[ning] ... waited 40-50 min from 5:25 pm on for meal to be served ..."</p> <p>Investigation: blank. Resolution: "... Food Service Worker came to me this morning and told me she had a difficult time at serve out last night - we discussed ways to improve this."</p> <p>* 5/27/15 Resident reported to staff - "Multiple complaints[:] call lights ... couldn't find staff to help her." Investigation: "All ..nursing concerns were taken care of at the time ..." Resolution: "While speaking w/ [Resident's name] ... she moved on to telling me about missing clothes."</p> <p>* 6/23/15 Resident reported to staff - "Was last table served and ... asked me why he didn't have his tray. This was at 6 PM." Investigation: "Late start to serve out - 5:30 PM long serve out." Resolution: "Promised resident he would not be the last table the next day. [Resident's name] is appreciative of the efforts."</p> <p>Refer to F 315 for details regarding incontinence issues.</p> <p>c) On 6/29/15 from 10:00 a.m. to 11:40 a.m., a Group Interview with 20 residents was conducted. During that time, 5 residents said they had waited 15 minutes or longer for staff assistance, 2 said they had waited 30 minutes or longer and 1 resident said his roommate had waited "half an hour" for assistance. Ten residents said there was only 1 nurse and 2 or 3 CNAs on the night shift. One resident stated, "There's not enough help if it goes bonkers ... [and] ... it goes bonkers 1 to 2 times a week." Four other residents agreed with the "bonkers" statements. One resident said the</p>	F 353			

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F 353	<p>Continued From page 32</p> <p>facility is "fully staffed but understaffed." A majority of the residents agreed with that statement. Fourteen residents agreed with another resident who stated, "They [staff] work hard but there just aren't enough of them." Seven residents said they only get to shower 1 to 2 times a week and in the summer heat that is not enough. The residents said they want to be able to shower more often, but there are not enough staff to help. When asked about meal times, 11 residents said meal times were not consistent and that meals were frequently served 20 to 30 minutes late in the Main dining room. Eight residents agreed with a resident who stated, "Sometimes they don't have enough servers."</p> <p>On 7/2/15 at 12:05 p.m., the Administrator and DNS were informed of concerns about inadequate staffing to meet residents' needs.</p> <p>3. Resident #6 was admitted to the facility 6/9/14 with multiple diagnoses, including hereditary and idiopathic peripheral neuropathy; generalized osteoarthritis; anxiety; bipolar disorder; vascular dementia with delirium; obsessive-compulsive disorders; and edema.</p> <p>The resident's 5/20/15 quarterly MDS assessment coded a BIMS score of 14 (intact cognition), extensive 1-person assistance for bed mobility, transfers, walking in room, locomotion on the unit, dressing, toilet use, personal hygiene, and bathing.</p> <p>On 6/29/15, when asked if she received assistance/help when she needed it, the resident stated, "Sometimes you have to wait a bit. It depends on if they're busy or not." When asked what "a bit" was, the resident stated, "Fifteen to</p>	F 353			

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F 353	Continued From page 33 20 minutes. Most of the time it's 5 to 10 minutes." When asked if any staff ever turned the call light off and said they would be back before they provided any assistance, the resident stated, "All the time, then it's another 15 to 20 minutes." The resident said this had happened "often" and on all shifts. The resident stated, "It gets harder and harder to hold it [urination]." When asked if she receives assistance/help at bedtime, the resident stated, "I have to wait sometimes. It depends on if they're busy or not," and that staff are "pretty busy often." The resident stated, "I wouldn't call them if I didn't need their help."	F 353			
F 369 SS=D	483.35(g) ASSISTIVE DEVICES - EATING EQUIPMENT/UTENSILS The facility must provide special eating equipment and utensils for residents who need them. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, it was determined the facility did not ensure special eating equipment was provided for residents who needed it. This was true for 1 of 9 (#7) sampled residents and 2 random residents (#s 16 and 17) reviewed for adaptive equipment. This deficient practice had the potential to cause more than minimal harm should residents experience a compromised nutritional status. Findings included: 1. Resident #7 was admitted to the facility on 6/5/14 with multiple diagnoses including aftercare for healing traumatic fracture of hip, generalized osteoarthritis, paralysis agitans (Parkinson's Disease), muscle weakness, lack of coordination,	F 369	F 369 The facility must provide special eating equipment and utensils for residents who need them. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Residents #7, 16 and 17 were affected by this deficient practice. The dietary manager immediately took measures to correct the errors by removing the inappropriate equipment and provide the residents with appropriate adaptive equipment.	7/31/15	

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F 369	<p>Continued From page 34</p> <p>stiffness of joints, reactive confusion, adjustment disorder with anxiety and dementia with behavioral disturbances.</p> <p>Resident #7's care plan for the focus of alteration in nutrition related to Parkinson's Disease, agitation, exhibited by poor intake with potential for weight loss, initiated 6/11/14, documented, "Has lipped plate to assist while eating, monitor Q [every] meal for appropriate usage, initiated 2/25/15."</p> <p>On 6/28/15 at 5:40 PM, Resident #7 was observed in the North Dining Room eating a regular diet of lasagna and mixed vegetables on a regular plate. The resident's preference card, placed by his plate, documented, "Adaptive Equipment: Lip Plate."</p> <p>On 6/28/15 at 5:45 PM, LN #4 was directed to observe the resident's plate and asked if the resident had a lipped plate. LN #4 stated, "No, that is a regular plate."</p> <p>2. Random Resident #16 was admitted to the facility on 8/22/11 with multiple diagnoses, including aortic aneurysm, contracture of hand joint, and dementia.</p> <p>Random Resident #16's care plan for the focus of nutritional problem related to dementia, initiated 1/3/14, documented, "Has divided plate and straight built-up utensils to assist while eating meals," initiated 5/24/15.</p> <p>On 6/28/15 at 5:40 PM, Random Resident #16 was observed in the North Dining Room eating a regular diet of lasagna and mixed vegetables on a lipped plate. The resident's preference card,</p>	F 369	<p>How will you identify other residents having the potential to be affected by the same deficient practice and actions that will be taken?</p> <p>All residents have the potential to be affected by this deficient practice. Resident care plans will be audited and cross referenced against resident diet cards/slips to ensure appropriate usage of adaptive equipment.</p> <p>What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <p>Root Cause Analysis findings showed that not all staff were knowledgeable regarding various types of adaptive equipment.</p> <p>Dietary and nursing staff will be inserviced on the use of adaptive equipment.</p> <p>How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?</p> <p>Dietary Manager or designee will conduct audits of adaptive equipment use in the dining room. Random audits of care plans will be audited and cross referenced against resident diet cards/slips.</p> <p>Audits will be completed weekly (x4), biweekly (x2), monthly (x1) and report findings to QA monthly (x3).</p>		

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F 369	<p>Continued From page 35</p> <p>placed by his plate, documented, "Adaptive Equipment: Divided Plate."</p> <p>On 6/28/15 at 5:45 PM, LN #4 was directed to observe the resident's plate and asked if the resident had a divided plate. LN #4 stated, "The resident has a lipped plate but not a divided plate." When shown the preference card, LN #4 stated, "Yes, he should have a divided plate." The CDM (certified Dietary Manager) walked up to the table and stated, "Yes, this is a lipped plate, not a divided plate."</p> <p>3. Random Resident #17 was admitted to the facility on 6/5/15 with multiple diagnoses, including paralysis agitans, and hemiplegia affect nondominant side due to cerebrovascular disease.</p> <p>On 6/28/15 at 5:40 PM, Random Resident #17 was observed in the North Dining Room eating a regular diet of lasagna and mixed vegetables on a lipped plate with regular utensils. The resident's preference card, placed by his plate, documented, "Adaptive Equipment: "Built-Up Utensil Handles, Lip Plate."</p> <p>On 6/28/15 at 5:45 PM, LN #4 was directed to observe the resident's utensils and asked if the resident had built-up utensils. LN #4 stated, "No, he does not have built-up utensils." LN #2 walked up to the table and stated, "Those are not built-up utensils."</p> <p>On 7/2/15 at 8:10 AM, the CDM stated, Random Resident #16 had a similar name as another resident in the facility and at meal service the trays got switched and the other resident received Random Resident #16's divided plate. The CDM</p>	F 369			

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F 369	Continued From page 36 stated, "Neither resident is diabetic and both had regular diets. The names are similar and they got switched. When I found out, I brought [Random Resident #16] a new dinner on a divided plate." The CDM stated Resident #7's preference card should have a star displayed in the upper right-hand corner, which would indicate to the cook the resident should be given a lipped plate. However, this particular preference card did not show a star. The CDM stated, "It has been corrected." Regarding Random Resident #17, the CMD stated, "Built-up utensils was a recent addition and it was missed." On 7/2/15 at 12:05 PM, the Administrator and DON were made aware of the concerns with adaptive equipment. No further information was received from the facility which resolved the concern.	F 369			
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.	F 441		7/31/15	

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F 441	<p>Continued From page 37</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, it was determined the facility failed to ensure staff adhered to standard infection control practices for 3 of 9 sample residents (#s 3, 5 and 6). Failure to post pertinent signage at/by Resident #3's door created the potential of unknowing visitors, residents or staff to spread C-diff (Clostridium difficile, a bacterial spore-forming rod); and, staff's failure to perform hand hygiene after direct contact with Residents #5 and #6 created the potential for cross-contamination of infection-causing organisms. Findings included:</p> <p>1. Resident #3 was admitted to the facility on 1/9/14 with multiple diagnoses, including</p>	F 441	<p>F 441 The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Residents #3, 5, and 6 were affected by this deficient practice. Staff will be inserviced on hand hygiene, contact precautions and documentation.</p>		

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F 441	<p>Continued From page 38</p> <p>psychosis, paranoid schizophrenia, adult failure to thrive, peripheral vascular disease, and acute osteomyelitis of the ankle and foot.</p> <p>The clinical record documented the resident underwent a partial amputation of the left great toe on 6/5/15. On 6/10/15, the physician ordered Augmentin (antibiotic) twice a day for 7 days, which was completed by 6/17/15. Diarrhea was noted on 6/17/15 and 6/18/15. A stool sample was noted as positive for C-diff on 6/19/15 and the resident was moved to a private room with a private bathroom that day.</p> <p>The resident's 6/8/15 quarterly MDS assessment documented: no problem understanding others or being understood; no short- or long-term memory problems; one person supervision with transfers, toilet use and personal hygiene; and no urinary/bowel incontinence.</p> <p>The resident's care plan included the Focus areas * "[Resident's name] is sometimes unable to make it to the bathroom on time once he's outside smoking ... can cause outside defecation" initiated 5/27/15. Interventions included, "... has agreed to wear adult depends [sic] to help ensure no further accidents outside." * "The resident has C. Difficile" initiated/ revised on 6/22/15 - Interventions, all of which were initiated 6/22/15, included, "Educated resident/family/staff regarding preventive measures to contain the infection ... [F]ollow facility protocol for precautions ... The resident requires supervision assistance with hand washing after being toileted and before and after meals."</p>	F 441	<p>How will you identify other residents having the potential to be affected by the same deficient practice and actions that will be taken?</p> <p>All residents have the potential of being affected by this deficient practice. All staff including ancillary staff will be inserviced on hand hygiene and contact precautions.</p> <p>What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <p>Root Cause Analysis findings showed that additional education was needed on hand hygiene and infection control practices.</p> <p>Infection Control procedures to be reviewed and updated by RN Manager or designee. RN Manager or designee will complete competency exams on Hand hygiene and contact precautions with all staff.</p> <p>How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?</p> <p>RN Manager or designee will complete observational audits of employee infection control practices, including hand hygiene and contact precautions. Signage indicating that additional precautions may be indicated will be placed on all isolation carts/kits and interventions and posting of</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135133	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/02/2015
NAME OF PROVIDER OR SUPPLIER IDAHO STATE VETERANS HOME - LEWISTON			STREET ADDRESS, CITY, STATE, ZIP CODE 821 21ST AVENUE LEWISTON, ID 83501		
(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 441	<p>Continued From page 39</p> <p>On 6/28/15 at 4:20 p.m., during the initial tour of the facility with the DNS, the DNS stayed in the hall and did not say anything when the surveyor entered Resident #3's room after no response to knocks at the door. As the surveyor turned to leave the resident's room, a small 3-drawer cart was observed inside the room by the door to the hallway. When asked about the cart, the DNS said it was for "contact precautions" for "C-diff." When asked why there was no pertinent signage at/by the resident's door, the DNS stated, "Because we communicate the precautions to all of our staff." The DNS nodded yes when asked if housekeeping, laundry, dietary, and maintenance staff also received communication about the precautions. When asked about signage for visitors and other residents, the DNS said the resident did not spend "much time" in his room, did not have visitors, and none of the residents wandered. However, when asked about the surveyor as a visitor, the DNS nodded 'yes' and indicated that signage would be posted at/by the door.</p> <p>No signage was observed posted at/by the resident's door on 6/29/15 at 11:55 a.m., 1:20 p.m. and 1:50 p.m. or on 6/30/15 at 10:10 a.m. and 2:00 p.m.</p> <p>On 6/30/15 at 2:00 p.m., while LN #1 and the surveyor were in the room with the resident, the small cart was observed not to be in the room. When asked about the missing cart, the LN stated, "Contact isolation was DC'd [discontinued] this morning because it was the 3rd day of formed stools."</p> <p>On 7/1/15 at 3:00 p.m., the DNS was interviewed and the Interim Nurse Manager (INM) was</p>	F 441	<p>signage will be carried out by licensed staff when indicated.</p> <p>Audits will be completed weekly (x4), biweekly (x2), monthly (x1) and report findings to QA monthly (x3).</p>		

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F 441	<p>Continued From page 40</p> <p>present. When asked about the lack of signage at/by the resident's door, the DNS stated, "We don't generally do the signage. We just in-service the staff and family." The DNS said the resident "doesn't have many visitors," and "His sister comes once every 2 weeks or so but they don't go in his room ... ever." When asked why contact precautions were discontinued on 6/30/15, the DNS stated, "Because he'd been over 48 hours without a loose stool."</p> <p>Review of the resident's June 2015 Progress Notes (PN) in the evening of 7/1/15, however, revealed documentation of "loose stool continues" on 6/30 at 12:34 p.m.</p> <p>On 7/2/15 at 9:20 a.m., during an interview with the DNS and Interim Nurse Manager (INM) about the Infection Control Program, the DNS was asked about the resident's 6/30/15 PN which documented "loose stool continues" just hours after contact precautions were dc'd. The DNS said that CNAs documented bowel continence and formed stools on 6/29 and 6/30/15. When asked which documentation was accurate, the DNS said the LN who documented loose stools on 6/30 was on duty. The INM went to get the LN and the DNS followed her moments later. When the DNS and INM returned, the DNS stated, "She [the LN] states she asked him but did not visualize the stools. The CNAs did visualize the stools." When asked if the LN was aware/informed that contact precautions were stopped the morning of 6/30/15, the DNS said "Yes." When asked what the LN did if she knew that contact precautions were stopped and the resident reported loose stools a short time later, the DNS stated, "We will do more in-services and that nurse will be counseled not just on infection</p>	F 441			

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F 441	<p>Continued From page 41 control but on communication. Other staff as well."</p> <p>2. On 6/29/15 at 3:10 p.m., CNA #5 was heard as she assisted Resident #6 with toileting in the restroom. The CNA asked the resident if she needed help with cleaning herself. The resident said, "Yes," and the CNA said she would "wipe" the resident's peri-area. Moments later, the CNA held onto a gait belt around the resident's waist as she assisted the resident to ambulate with her 4-wheeled walker from the restroom to her recliner. The CNA assisted the resident into the recliner then the CNA picked up the TV remote, showed it to the resident, and put the remote back on the over bed table. The CNA then moved the over bed table closer to the recliner. The CNA straightened the resident's bed linens, went back to the restroom and flushed the toilet, gathered up the trash, opened the door, and left the room. The CNA did not wash or sanitize her hands at any point during the resident encounter.</p> <p>Immediately afterward, CNA #5 was informed of the observation and asked if she had washed or sanitized her hands. The CNA stated, "No I did not. I should have." The CNA then sanitized her hands.</p> <p>3. On 6/30/15 at 12:10 p.m., LN #6 was observed as she administered a subcutaneous (SQ) injection to Resident #5. Following the injection, LN #6 removed her gloves and wheeled the resident out of her room and down the hall toward the common area. LN #6 did not wash or sanitize her hands before she left the resident's room, nor did she use sanitizer from any of the dispensers mounted on the walls along the hallway. When asked if she had washed or sanitized her hands,</p>	F 441			

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F 441	Continued From page 42 the LN stated, "I did not. I admit it."	F 441			
F 514 SS=D	On 7/2/15 at 12:05 p.m., the Administrator and DNS were informed of the infection control issues. The facility did not provide any other information which resolved the issues. 483.75(I)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility failed to ensure the clinical record was accurate for 1 of 13 sample residents (#3). Conflicting documentation regarding Resident #3's bowel function created the potential for premature discontinuation of contact precautions for C-diff (Clostridium difficile). Findings included: Resident #3's clinical record contained documentation that contact precautions were started on 6/19/15 for loose stools positive for	F 514	F 514 The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?	7/31/15	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135133	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/02/2015
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F 514	<p>Continued From page 43</p> <p>C-diff. The record documented that the precautions were discontinued in the morning on 6/30/15, however staff documented later that same day that the resident's "loose stool continues."</p> <p>When interviewed on 7/1/15 and 7/2/15, the DNS said the resident was continent and had formed stools for more than 48 hours before the precautions were stopped. The DNS said that CNAs had visualized the formed stools and the LN had not. When asked which documentation was accurate, the DNS said the CNA documentation was accurate. Refer to F 441, Infection Control, for details.</p> <p>The facility did not provide any other information which resolved the issue.</p>	F 514	<p>Resident #3 was affected by this deficient practice. LN Responsible has been inserviced on accurate documentation and maintaining communication with un-licensed staff.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and actions that will be taken?</p> <p>All residents have the potential to be affected by this deficient practice. Licensed and unlicensed staff will be in-serviced on the importance of accuracy in nursing documentation and maintaining effective communication with each other.</p> <p>What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <p>The Root Cause Analysis showed that staff was not always communicating effectively with each other resulting in erroneous documentation. It was also discovered that not all staff was knowledgeable about how to obtain different types of information within the EMR.</p> <p>RN Manager or designee will inservice licensed staff on how to obtain various reports and view documentation within the EMR.</p> <p>How the corrective actions will be monitored to ensure the deficient practice</p>		

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

PRINTED: 11/09/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135133	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/02/2015
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F 514	Continued From page 44	F 514	<p>will not recur, i.e. what quality assurance program will be put into place?</p> <p>RN Manager or designee will audit the effectiveness of communication between licensed and unlicensed staff. RN Manager or designee will audit Licensed staff's ability to access information within the EMR.</p> <p>These audits will be done weekly (x4), biweekly (x2), and monthly (x1). Findings will be reported to the QA monthly (x3).</p>		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001311	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/02/2015
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NAME OF PROVIDER OR SUPPLIER IDAHO STATE VETERANS HOME - LEWISTON	STREET ADDRESS, CITY, STATE, ZIP CODE 821 21ST AVENUE LEWISTON, ID 83501
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C 762	<p>02.200,02,c,ii When Average Census 60-89 Residents</p> <p>ii. In SNFs with an average occupancy rate of sixty (60) to eighty-nine (89) patients/residents a registered professional nurse shall be on duty for each a.m. shift (approximately 7:00 a.m. - 3:00 p.m.) and p.m. shift (approximately 3:00 p.m. to 11:00 p.m.) and no less than a licensed practical nurse on the night shift.</p> <p>This Rule is not met as evidenced by: Based on review of a 3 week nursing schedule provided by the facility, it was determined the facility did not meet the State requirement for registered professional nurse (RN) coverage when the resident occupancy rate was between 60 and 89 residents for each of the days reviewed. Additionally, the facility did not meet the minimum staffing requirement of 2.4 hours per resident per day. Inadequate RN and staff coverage had the potential to negatively affect all residents living in the facility. Findings included:</p> <p>Review of the 3 week nursing schedule for 6/7/15 through 6/27/15 revealed the following for RN coverage on Day Shift (approximately 7:00 AM - 3:00 PM):</p> <ul style="list-style-type: none"> * 6/9 = 5.1 hours, resident census 64. <p>RN coverage on the Evening Shift (approximately 3:00 PM - 11:00 PM):</p> <ul style="list-style-type: none"> * 6/9 = 0 hours, resident census 64; * 6/13 = 0 hours, resident census 64; * 6/18 = 0 hours, resident census 63; * 6/20 = 0 hours, resident census 63; * 6/22 = 0 hours, resident census 63; and, * 6/27 = 0 hours, resident census 64. <p>The facility failed to meet the requirement for 8</p>	C 762	<p>C 0762 In SNFs with an average occupancy rate of sixty (60) to eighty-nine (89) patients/residents a registered professional nurse shall be on duty for each a.m. shift. (approximately 7:00 a.m. - 3:00 p.m.) and p.m. shift (approximately 3:00 p.m. to 11:00 p.m.) and no less than a licensed practical nurse on the night shift. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Residents #2, 7, 9, 10, 11, and 13 were affected by this deficient practice. The DNS and RN Manager reviewed staffing for licensed and un-licensed staff and modified staffing patterns for all three shifts and moved staff according to the needs of the residents. Additional staff have been hired to ensure adequate licensed and un-licensed staff are</p>	7/31/15

Bureau of Facility Standards
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

08/04/15

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001311	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/02/2015
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C 762	<p>Continued From page 1</p> <p>hours of RN coverage during the shifts when the facility census was between 60 and 89 residents. The facility Total Time Report (time sheets used for payroll) were reviewed to confirm the lack of coverage on the identified dates.</p> <p>Review of the 3 week nursing schedule for 6/7/15 through 6/27/15 revealed the facility did not meet the minimum staffing requirement of 2.4 hours per resident per day for the following: * 6/7, 6/12, 6/13, 6/14, 6/20 and 6/27.</p> <p>On 7/2/15 at 10:30 AM, the DON and Administrator were advised of the findings. No further information was provided by the facility which resolved this concern.</p>	C 762	<p>available to provide ADL's as well as meeting mandatory PPD requirements.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and actions that will be taken?</p> <p>All residents have the potential to be affected by the deficient practice. The DON and RN Manager will review staffing for licensed and un-licensed staff and modify staffing patterns to ensure the needs of the facility's residents are being met as well as meeting mandatory PPD requirements.</p> <p>What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <p>Root Cause Analysis findings showed that the number of staff was adequate, but identified additional needs of more staff members on different shifts.</p> <p>The DNS and RN Manager reviewed staffing for licensed and un-licensed staff and modified staffing patterns for all three shifts and moved staff according to the needs of the residents. Additional staff have been hired to ensure adequate licensed and un-licensed staff are available to provide ADL's as well as meeting mandatory PPD requirements.</p> <p>How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance</p>	

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C 762	Continued From page 2	C 762	<p>program will be put into place?</p> <p>RN Manager or designee will review and modify staffing patterns of licensed and un-licensed staff for all shifts. The RN Manager or designee will monitor hours worked to ensure compliance of Federal and State requirements.</p> <p>Social Services, RN Manager or designee will ensure residents' needs are being met and staffing is in compliance to meet those needs by monitoring Grievance forms r/t resident needs and ensure resident concerns are decreasing and needs are being met. Call light times will also be monitored to ensure they are beng answered in a timely manner.</p> <p>RN Manager or designee will conduct audits to ensure staffing patterns meet the needs of the residents and comply with Federal and State requirements.</p> <p>Audits will be completed weekly (x4), biweekly (x2), monthly (x1) and report findings to QA monthly (x3).</p>	



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

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October 8, 2015

Kenneth Shull, Administrator
Idaho State Veterans Home - Lewiston
821 21st Avenue,
Lewiston, ID 83501-6389

Provider #: 135133

Dear Mr. Shull:

On **July 2, 2015**, an unannounced on-site complaint survey **OR** investigation of an entity-reported incident was conducted at Idaho State Veterans Home - Lewiston. The complaint allegations or entity-reported incidents, findings and conclusions are as follows:

Complaint or Entity-Report Incident #ID00006963

ALLEGATION #1:

The complainant stated the facility was understaffed to meet resident needs and did not have bath aides. The facility had a current census of 65 residents and all shifts were staffed with the same number of CNA's, which was two-three. The AM and PM shifts had four licensed staff, but the night shift only had one RN.

FINDINGS #1:

The complaint was investigated in conjunction with the facility's on-site Recertification and State Licensure survey conducted on June 28, 2015 to July 2, 2015.

***The following observations were made:

- Direct care staff and management staff interactions with the identified resident and multiple other residents;
- Meal observations of the identified resident and multiple other residents; and,
- Direct care staff during the provision of care to the identified resident and eight other residents.

The following documents were reviewed:

- The medical records for 13 residents, including the identified resident;
- The facility's grievance files, incident and accident reports and reports of allegations of abuse;
- Resident Council meeting minutes;
- Facility list of residents who required the assistance of two staff;
- Call light logs; and,
- Staffing hours records.

The following interviews were completed:

- A group of residents were interviewed and several individual residents were interviewed regarding quality of care concerns;
- Several direct care staff were interviewed regarding quality of care concerns;
- Two Social Workers were interviewed regarding quality of care concerns; and,
- The Director of Nursing was interviewed regarding various quality of care concerns.***

Based on record review and staff interviews, it was determined the allegation was substantiated and the facility was cited at F-353 and C-762.

CONCLUSION: Substantiated. Federal and State deficiencies related to the allegation are cited.

ALLEGATION #2:

The complainant stated that basic grooming was not occurring consistently and residents were not toileted when only two-three CNAs worked a shift due to the number of residents who required two-person assistance or required a Hoyer Lift.

FINDINGS #2:

Based on record review and staff interviews, it was determined the allegation was substantiated and the facility was cited at F-353 and C-762.

CONCLUSION: Substantiated. Federal and State deficiencies related to the allegation are cited.

ALLEGATION #3:

There have been more than 100 falls and staff need to be more responsive to call lights and toilet residents more often

FINDINGS #3:

Based on record review and staff interview, it was determined the allegation was substantiated and the facility was cited at F-315.

CONCLUSION: Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #4:

The complainant stated an identified resident, who was alert and oriented, required the assistance of two staff. The identified resident was continent if staff responded in a timely manner, but the number of incontinent episodes was increasing.

FINDINGS #4:

The identified resident was interviewed and stated she needed the assistance of two staff. She did not express any concerns regarding assistance or staff response when needed; this allegation was not substantiated.

CONCLUSION: Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #5

The complainant stated an identified resident asked for help with toileting, but staff were unable to help in a timely manner. As a result, the resident was incontinent of bowel and bladder, which was very upsetting to him.

FINDINGS #5:

The identified resident was interviewed, verified the incident, and stated it was very upsetting to him. Based on record review, resident and staff interviews, it was determined the allegation was substantiated and the facility was cited at F-315, F-353, and C-762.

CONCLUSION: Substantiated. Federal deficiencies related to the allegation are cited.

Kenneth Shull, Administrator
October 8, 2015
Page 4 of 4

Based on the findings of the investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this findings letter, as it will be addressed in the provider's Plan of Correction.

If you have questions, comments or concerns regarding our investigation, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

DAVID SCOTT, RN, Supervisor
Long Term Care

DS/pmt



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

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October 7, 2015

Kenneth Shull, Administrator
Idaho State Veterans Home - Lewiston
821 21st Avenue,
Lewiston, ID 83501-6389

Provider #: 135133

Dear Mr. Shull:

On **July 2, 2015**, an unannounced on-site complaint survey **OR** investigation of an entity-reported incident was conducted at Idaho State Veterans Home - Lewiston. The complaint allegations or entity-reported incidents, findings and conclusions are as follows:

Complaint or Entity-Report Incident #ID00006700

ALLEGATION #1:

An identified resident whom had behaviors was left in a recliner for hours at a time due to insufficient staff and was unable to be redirected and reapproached to get out of the chair. The resident had sores on his/her back. The RP was unsure if the sores were pressure related.

FINDINGS #1:

The complaint was investigated in conjunction with the facility's on-site Recertification and State Licensure survey conducted June 28, 2015 to July 2, 2015.

The following observations were made:

- Direct care staff and management staff interactions with the identified resident and multiple other residents;
- The identified resident and multiple other residents during meal times; and,
- Direct care staff during the provision of care to the identified resident and eight other residents.

The following documents were reviewed:

- The medical records for 13 residents, including the identified resident;
- The facility's grievance files, incident and accident reports and reports of allegations of abuse;
- Resident Council meeting minutes;
- The facility's list of residents who needed assistance of two staff;
- Call light logs; and,
- Staffing hours records.

The following interviews were completed:

- A group of residents were interviewed and several individual residents were interviewed regarding quality of care concerns;
- Several direct care staff were interviewed regarding quality of care concerns;
- Two Social Workers were interviewed regarding quality of care concerns; and,
- The Director of Nursing was interviewed regarding various quality of care concerns.

Based on the observations, record reviews and interviews, the allegation was substantiated and the facility was cited at F 353 and C-762.

CONCLUSION: Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #2:

One identified resident and an unidentified resident have fallen, without major injury, in the past month due to lack of staff supervision. The complainant stated these residents really should be one-to-one, but are not due to lack of staff.

FINDINGS #2:

It could not be established that the identified resident had fallen due to lack of supervision. In addition, the unidentified resident could not be identified. The allegation was unsubstantiated and deficient practice was not identified.

CONCLUSION: Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

Call lights are answered within four-to-ten minutes, but due to lack of staff, the staff turn the lights off, tell the resident they will be back and then can't get back to them for another fifteen minutes.

FINDINGS #3:

Based on review of grievances and interviews, the staff turned off residents' call lights without attending to the residents' needs in a timely manner. The allegation was substantiated and the deficient practice was cited at F 353 and C 762.

Kenneth Shull, Administrator
October 8, 2015
Page 3 of 4

CONCLUSION: Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #4:

The facility is constantly short one-to-two CNAs each day. This is not enough because the facility has a lot of two-person assists and they can't meet all the needs of the residents. Nurses rarely help the CNAs when staff is short.

FINDINGS #4:

Based on observations, interviews, records review and review of the facility's list of residents who needed assistance of two staff, it was determined there was inadequate staff to provide for the needs and care of residents. The allegation was substantiated and the deficient practice was cited at F 353 and C 762.

CONCLUSION: Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #5:

Male residents often wear the same undershirts for two or three days because staff don't have time to change them. They will be put to bed in them and then the morning shift will just leave the undershirts on them the next day. This will happen each day until their bath day, when they get new clothes and undershirts.

FINDINGS #5:

Based on observations, interviews and record reviews, it could not be established that male residents wore the same undershirts for multiple days or that residents were put to bed in the same undershirts because staff did not have time to change them. The allegation was unsubstantiated and deficient practice was not identified.

CONCLUSION: Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #6:

Toothbrushes are not replaced in a timely manner and are "disgusting" because CNAs do not have time to replace them since they are overworked.

FINDINGS #6:

Based on observations, interviews, and record reviews, it could not be established that toothbrushes were not replaced in a timely manner or that the toothbrushes were disgusting because CNAs did not have time to replace them since they were overworked. The allegation was unsubstantiated and deficient practice was not identified.

Kenneth Shull, Administrator
October 8, 2015
Page 4 of 4

CONCLUSION: Unsubstantiated. Lack of sufficient evidence.

Based on the findings of the investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this findings letter, as it will be addressed in the provider's Plan of Correction.

If you have questions, comments or concerns regarding our investigation, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

DAVID SCOTT, RN, Supervisor
Long Term Care

DS/pmt